VA FISCAL YEAR 1986 MEDICAL PROGRAM BUDGETS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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HEARING ON VETERANS' ADMINISTRATION FISCAL YEAR 1986 MEDICAL PROGRAM BUDGETS

THURSDAY, FEBRUARY 7, 1985

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:30 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Evans, Kaptur, Mollohan, Penny, Rowland of Georgia, Robinson, Hammerschmidt, Johnson, Molinari, Ridge and Hendon.

Mr. EDGAR. The Subcommittee on Hospitals and Health Care will come to order. I want to thank all of you for coming.

I have an opening statement that I would like to read, and then I will yield to my colleague, John Paul Hammerschmidt, for his opening statement.

Some of you know that I had asked the Administrator, Harry Walters, to come before this subcommittee in September to carefully examine the document which was released by the VA dealing with the aging problem; that is, the number of veterans who are reaching the age of 65 and their impact on the system. Harry Walters chose at that time to respectfully decline that invitation and, therefore, the report, which was released late on a Friday afternoon, has not really had a public hearing.

My fear—and I talked to John Paul Hammerschmidt and some others about it—was that, given the implications of the report it was important for us to carefully consider it. The chairman will, in fact, have a full hearing of our full committee on all of the budget issues later this month and we will fully participate in that hearing.

Today we are very pleased to have the Chief Medical Director to focus some attention on concerns that have been raised in terms of the budget reflected in the health care area. Specifically I have concerns dealing with the aging veteran problem and some of the construction issues. If we waited until Harry Walters comes to respond to those questions on Feb. 20th, it might be too late. In fact, there may be some questions raised in this hearing this morning that we will want to get further clarification on at the later full committee hearing.

I want to welcome all of you to the first Subcommittee on Hospitals and Health Care hearing for the 99th Congress. We have two new Democratic members of the subcommittee this year. Paul Kanjorski from my home State of Pennsylvania and Tom Robinson of the great State of Arkansas are new to the subcommittee and to the Congress as well.

John Paul, I wonder if you would at this point want to introduce or at least list the names of your new members and then we'll begin.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman. Again, we certainly look forward to working with you during the 99th Congress.

We have four new members on our side, and each of them has a particular interest in VA hospitals and health care, and each of them will certainly be a fine addition to our subcommittee.

We have present here this morning Guy Molinari of the fourth District of New York. He is beginning his third term in Congress. I also am pleased, as you are, Mr. Chairman, to serve with him on the Public Works Committee. He's a lawyer and a Marine Corps veteran of the Korean war. He served in the New York State Assembly.

Then we have other members who are not here at the moment. Tom Ridge of the 21st Congressional District of Pennsylvania is beginning his second term. He's an honor graduate of Harvard and is also a lawyer. He's a decorated combat veteran of Vietnam.

Then we have Bill Hendon of the 11th District of North Carolina. He was first elected to the Congress in 1980. He lost a close race in 1982 but was elected again in 1984. He both graduated from and taught at the University of Tennessee. He also taught at two other colleges in North Carolina. He has a business and manufacturing background.

Then lastly as a member of our subcommittee, a new member, we have John Rowland of the fifth District of Connecticut. He was elected to that State's house of representatives when he was 22 years of age. He served two terms and was the minority whip. He is a business administration graduate of Villanova and has been in the insurance business. At age 27, he is the youngest Member of the 99th Congress.

Thank you, Mr. Chairman. I will have more to say after you make your opening statement.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. EDGAR. Mr. Hammerschmidt, I would like to point out that the last new member from your side who graduated from Villanova ia actually from my district, so we're pleased to have him as a Member of Congress.

We are meeting this morning to receive testimony from the VA's Department of Medicine and Surgery on the VA's fiscal year 1986 medical budget. The VA's proposed fiscal year 1986 medical care budget concerns me in many areas, and I am especially interested to know how the VA plans to address the workload which is forecast in the VA's report, "Caring for the Older Veteran."

The subcommittee is interested in learning how the VA plans to implement proposed legislative initiatives described in the budget

which would reform the eligibility for VA medical care, including a means test and elimination of the provision which makes veterans over the age of 65 eligible for VA hospital care.

We also would like to hear the details on the proposal to require reimbursement from private insurance plans for VA care provided to non-service-connected disabled veterans.

The fiscal year 1986 budget also proposes drastic reductions in construction funds which will delay construction of major replacement/modernization hospital projects, including hospitals in Augusta, GA, New York City, Houston, TX, and Philadelphia, PA. These deferrals will not only delay the needed upgrade of health care delivered to veterans in these geographic areas, but will end up costing the taxpayers more money due to the inflationary impact caused by delaying construction.

Last year the committee added $50 million to the medical care budget to provide an increase in the number of outpatient visits due to a freeze on that account from the previous year. This budget proposal freezes the number of inpatients that can be treated in VA hospitals while only providing a modest increase in VA nursing home and outpatient staffing. These modest increases will not permit the VA to keep pace with the increasing demand for these types of care. Inevitably, the result will be that more veterans seeking VA care will not be able to obtain it.

Also proposed are reductions in VA hospital beds and staff, as well as no funding for program improvements such as adult day health care services and geriatric evaluation units, which this committee evaluated, studied, and supported in the past. When we consider the drastic shortfalls for these services which we learned about in the field hearings held in all six of the VA's medical regions, I cannot understand how the administration can make these proposals in all good conscience.

I am also concerned about reductions in the research program, as well as the State Home Program.

I would like to direct the attention of the Members to the chart in your folders. This chart is an update of a previous chart, and looks at the actual dollars given to all medical programs versus the deflated dollar—that is, the dollars minus inflation. This is 1975 through 1986. You will see, in fact, that those dollars remained constant. This year, in the 1986 budget, we will see a decrease from $3.8 to $3.7 billion.

The top line of the graph shows a modest increase of approximately $200 million in medical programs, while the bottom line, which is deflated to fiscal year 1975 dollars, is the real bottom line of no growth in medical programs for the last 10 years. In fact, there is a reduction from last year. This is at the same time that we have increased the programs into the VA health care system.

[The chart appears at p. 35:]

Mr. EDGAR. I really look forward to the testimony today to learn how the proposed budget will meet the health care needs of our Nation's veterans.

Before I introduce our witnesses, I would now like to recognize the ranking member, John Paul Hammerschmidt, for any additional remarks he has before I introduce the Chief Medical Director.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

The President's fiscal year 1986 budget, as it relates to medical care for veterans, calls for an appropriation of in excess of $9.3 billion. This includes funds for research, medical administration, grants for State extended care facilities, and a grant to the Republic of the Philippines. This total is some $200 million over the appropriation for 1985.

Mr. Chairman, the VA medical budget is big because it's mission is big. In my view, that mission is involved with a national commitment that each of us wants to honor in the best way we can. There are some of us who may question how the commitment can best be met in terms of its future, but in seeking answers to such questions, I would hope that we resolve to properly maintain the base of the VA medical system. By this, I mean a continuation of quality care for veterans, a continuation of good medical education and good academic affiliations, and a continuation of a good research program. In my judgment, these three elements are expertly intertwined in a way that has permitted the VA to perform its medical functions with limited total resources.

The VA medical budget before us is a lean and frugal one, as it ought to be. It may be too lean; it may be too frugal. I trust that our witnesses this morning will be candid with their testimony and when they answer our questions. If the budget embarks us on a path that will reduce the VA's effectiveness, change its mission, or materially changes its methods of providing care to veterans, we need to know about it now so that we can properly discharge our responsibilities.

I am sure, Mr. Chairman, that there are VA medical management techniques that can be improved upon. This budget contemplates saving 1,916 positions by such improvements. We need to know the details. The budget contemplates average employment being up by 199 positions. We need to know the base from which that figure is calculated. The budget says more patients will be treated in 1986 than in 1985. Hopefully, VA witnesses will also speak to that issue.

Mr. Chairman, we know that the VA is planning a means test for non-service-connected care. It is planned to consider what action to take on its report on the aging veteran. It is planning new activations and submission changes with respect to its mix of beds. Each thing it does or plans impacts on its total delivery system, and each has a price tag on it.

As these witnesses lead us through the budget this morning, it would be very helpful if they spell out where we can really expect the budget to lead us in fiscal year 1986.

Mr. Chairman, everyone in Congress needs to be doing what they can to reduce the Federal deficit. No agency of Government and no program can be exempt from national scrutiny. But there are some programs that ought to have a very high national priority. The VA medical program is such a program. As we consider our future actions with respect to the matters before us, we ought to, and I am sure we will, keep that priority in the forefront of our minds.

Mr. Chairman, I earlier mentioned the VA report on the aging veteran. You commented on that report this morning at our organizational meeting. I am sure that each member of the subcommittee shares your interest in it and concern about it. In many ways, it foretells the future of VA medicine. Therefore, the Agency's budget must reflect present and future considerations of its findings and recommendations.

As this and additional hearings are held, I would hope that we study that report in great detail and that VA witnesses will keep us up-to-date on what actions are contemplated in this area.

Finally, Mr. Chairman, Dr. John Ditzler is making his first appearance before us as the Chief Medical Director. He has a high responsibility, but he also has very high credentials. I know that we all wish him well as he pursues his difficult task. Mr. Chairman, I know you are anxious to introduce him as our first witness.

Thank you, sir.

Mr. EDGAR. Thank you very much. It is a pleasure to have Dr. John Ditzler as our first witness sitting in the "hot seat" this morning. We hope that as we proceed this morning you won't find us too hostile, but we appreciate your coming this morning to participate. We also want to recognize the fact that you come with a great deal of experience as a former hospital director and someone who has worked in the VA here in Washington in the past. We are pleased to have you directing the medical area of the Veterans' Administration.

Before you begin your testimony this morning, it would be helpful for the record if each of your colleagues sitting on the panel with you could identify themselves.

STATEMENT OF JOHN W. DITZLER, M.D., CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, ACCOMPANIED BY JOHN A. GRONVALL, M.D., DEPUTY CHIEF MEDICAL DIRECTOR; JOHN H. MATHER, ASSISTANT CHIEF MEDICAL DIRECTOR FOR GERIATRICS AND EXTENDED CARE; MARJORIE R. QUANDT, ASSISTANT CHIEF MEDICAL DIRECTOR FOR ADMINISTRATION; AND JOSEPH P. TRAVERS, DIRECTOR, RESOURCE MANAGEMENT

Dr. DITZLER. To your extreme right is Dr. John Mather, who represents our interest in academic affairs, the aging process and geriatrics. To my immediate left is Miss Marjorie Quandt, our Assistant Chief Medical Director for Administration.

To your extreme left and my extreme right is Mr. Joe Travers, the head of our budget section that produces many of the figures you have before you. And to my immediate right is my Deputy Chief Medical Director, Dr. John Gronvall, who has taken an outstanding lead in preparing much of this budget. Since I have been on board only 3 months, I will probably turn to him for many answers.

Mr. EDGAR. We invite you at this point to proceed with your opening statement, which you can read or summarize, and then we'll proceed with questions.

Dr. DITZLER. Mr. Chairman, I thank you. I would like to read it in detail because, in part, I believe it will answer some of the questions raised in your introductory remarks.

The Veterans' Administration is committed to providing quality medical care to veterans both today and in the future. The Administrator of the Veterans' Administration will be proposing legislation to amend title 38, United States Code to reform medical care eligibility by establishing a means test for veterans of all ages, where applicable. This will enable us to concentrate our efforts and our resources on those veterans with service-connected disabilities, additional special category veterans, and on the non-service-connected veteran without resources to defray all or part of their health care expenses.

In addition, legislation will be proposed to effect reimbursement from third party insurance carriers for the cost of medical care and treatment for certain veterans with non-service-connected disabilities. These collections will be used to reduce the amount shown for resources applicable to the VA but will not impact the appropriation request for the medical care account.

The 1986 budget was carefully formulated to ensure that the very important goal of deficit reduction could be achieved while still providing timely, quality care to eligible beneficiaries.

MEDICAL CARE

The 1986 Medical care budget request provides for an increase of $235.6 million and 199 FTEE over the 1985 revised level. The $9,090,000,000 budget also reflects the governmentwide actions of 5-percent pay decrease, a continuing reduction in the number of GS/GM 11-15's, exclusive of title 38 employees, and projected increases in employee productivity. Patients treated are estimated to increase by 3,211, and outpatient visits should increase by 112,000. The 1985 estimate includes a rescission proposal of $10.3 million to reflect the Deficit Reduction Act of 1984, and a proposed supplemental of $72.5 million for increased 1985 pay costs. The 1985 average employment is now estimated at 191,849, a decrease of 2,092 below the authorized ceiling. This level will provide an appropriately balanced program with efficient utilization of personnel to achieve the 1985 workload objectives.

MAMOE BUDGET

Under Medical administration and miscellaneous operating expenses, commonly known as MAMOE, resources have been reduced for the effect of the 5-percent governmentwide pay reduction, the GS/GM 11-15 grade reduction, excluding title 38 employees, a 10-percent administrative reduction, and the phasing out of the Health Professional Scholarship Program. The 1985 employment level is estimated at 837, a level of 23 below the authorized ceiling to facilitate the achievement of the 1986 level of 753 which will allow better management of our 1985 resources.

MEDICAL AND PROSTHETIC RESEARCH BUDGET

For Medical and prosthetic research, which also includes the 5-percent pay and GS 11-15 grade reductions, excluding again title 38, the appropriation request is $187,080,000, a reduction of $5.3 million and 157 FTEE below the 1985 level.

This level includes $3.8 million for the continuing requirements of the Centers for Disease Control on the Agent Orange Epidemiology study and provides for inflation adjusted continuation of the 1985 project levels for Rehabilitation and Health services research programs. The employment reduction will be applied to the Medical research program and will affect only the lowest priority research.

OTHER MEDICAL PROGRAMS

Under grants for construction of State extended care facilities, the requested 1986 level is $22 million, a level which will allow progress in reducing backlog levels in this program.

We are requesting $500,000 for grants to the Republic of the Philippines in 1986, the same level as 1985. This grant supports the maintenance and upkeep of the Veterans Memorial Medical Center's physical plant and facilities.

Mr. Chairman, this concludes my opening remarks. I and members of my staff will be pleased to answer any questions from you or members of the subcommittee.

WORKLOAD ESTIMATE

Mr. EDGAR. Thank you very much for your statement.

We're going to operate this morning, given the full committee Chairman's recommendation, under the 5-minute rule, if we can. In fact, I'm going to try to stick to it as well. I would ask a question in one area and then yield to my colleagues who also have questions.

I would like to talk to you about workloads and what you're basing your numbers on. I have some information that the actual hospital workloads, with the latest available information, indicates that patients treated in the VA hospitals are 11,000 patients over the original estimate. Do you know if that's correct?

Dr. DITZLER. In 1984, we exceeded our projected level by approximately 12,000 patients treated.

Mr. EDGAR. And in terms of outpatients treated, it is my information, for actual first quarter fiscal 1985, that we are about at 4.8 million outpatient visits which is 320,000 over the original estimate or an increase of about 7.1 percent.

Dr. DITZLER. I believe that is accurate, sir.

MEDICAL CARE EMPLOYMENT CEILINGS

Mr. EDGAR. On October 25, 1984, we received a letter from the Comptroller General of the United States which listed out for medical care some personnel ceilings. Here listed is 193,941, which is the number of employees that you and the medical care area are able to employ for 1985's fiscal year budget. Is that the figure that

you agreed to as the figure that the Comptroller General of the United States indicated was the appropriate figure?

Dr. DITZLER. I believe, sir, that is correct for the beginning of fiscal year 1985.

Mr. EDGAR. Fiscal year 1985 was 193,941, is that correct?

Dr. DITZLER. That's correct.

Mr. EDGAR. Then can you tell me why in the President's budget submission the estimate of how many people you're going to employ in fiscal 1985 is 191,849, a reduction of some 2,092, or why in your statement there is the decrease of almost 2,000 employees? If your patient load is up 2.1 percent in the inpatient care, and 7.1 percent in the outpatient care over plan, how do you account for the administration now coming in and for 1985 not fully utilizing the number of employees that we appropriated and authorized and why your estimates are that much lower?

Dr. DITZLER. Mr. Chairman, as I understand it, the full funding of the pay raise was not provided. There was an absorption of some $107 million in the dollars required to fully support an employment level of 193,941.

Mr. EDGAR. Are you making the argument that we didn't give you enough money to fully fund those additional staff?

Dr. DITZLER. No, sir, not directly. I have a two-phased answer that I must present to you.

Since full funding for the pay raise was not provided, it would have been necessary to reprogram dollars, taking money from other accounts in order to support the 193,941. It is our belief that we can more appropriately handle the requirements of patient care by not reprogramming funds for the 193,941. In treating patients we have to consider costs of pharmacy and all the other costs associated with patient care, other than people. The issue was to either withdraw money from pharmacy and other funds such as equipment, or withdraw it from personal services. We propose an appropriate balance.

Mr. EDGAR. Dr. Ditzler, I understand your explanation, but I'm troubled by it. Because on page 23 of the conference report Mr. Boland's committee worked up a specific set of numbers. It says on page 23:

> This amount of funding is specifically intended to support 193,941 full time equivalent employees, with the understanding that, in accordance with established congressional practice, any additional pay costs necessary to support that FTEE level will be borne by the VA using funds made available by this measure, funds made available through the enactment of a supplemental appropriation, or through absorption of the cost or some combination thereof. The FTEE level does not include common service FTEE's.

It is my understanding that the Appropriations Committee and this committee was clear in giving you authority and funding for that full complement of staff, and I think what we're hearing in the President's budget submission is that you're not going to use that full complement of staff and that even with the additional workloads you don't think it's necessary to put that complement of staff in place to handle the number of veterans that are coming to the system. Is that correct?

Dr. DITZLER. A series of observations, sir, that I would respond to as follows:

I believe that it would be highly desirable to have 193,941 employees, but faced with the option of either paying people or not supplying drugs, we have considered a balance to be necessary. The appropriate balance that we have struck will enable us to provide the care necessary to the veterans we agreed to take care of.

Mr. EDGAR. Are you recommending to this committee any additional funding levels and an additional supplemental to give you the authority to fund that level of staffing?

Dr. DITZLER. Not at this time, sir.

Mr. EDGAR. So that you, as the Chief Medical Director, believe that the reduced level of staffing, even with the increased level of participation within the health care, is adequate to provide care within the VA?

Dr. DITZLER. I believe we can do the job, sir.

Mr. EDGAR. You're not asking for any additional pharmaceutical help or other support so that you could fully utilize the level of staffing that we're giving you?

Dr. DITZLER. I'm sure, sir, that we can always use more money, but I hope to be able to be efficient as well. We will struggle very valiantly but we'll do it.

Mr. EDGAR. I yield to my colleague, John Paul Hammerschmidt, who I think will yield as well.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Because one of our members has to leave for another important meeting, let me yield my time at this point to him, and then you can come back to me.

Mr. Molinari.

THIRD PARTY REIMBURSEMENTS

Mr. MOLINARI. I thank the gentleman for yielding.

Dr. Ditzler, I'm a new member of this subcommittee, by the way, and the committee, for that matter.

On page 1 of your testimony, the middle of the page, I was considering introducing legislation myself that apparently would do what you are proposing, to effect reimbursement from third party insurance carriers for the cost of medical care and treatment to veterans with non-service-connected disabilities.

Could you give us an idea as to the expected revenue flow that would stem from that type of legislation?

Dr. DITZLER. No, I cannot give you an accurate estimate until the proposed legislation is fully developed. We already have reimbursements from third parties for emergency situations in which there have been automobile accidents and for other reasons, such as workmen's compensation and other parties currently authorized by statutes.

We bill third parties now for medical care in certain areas of the world, and it is reimbursed, to the tune of about $20 million. This is not an entirely new event.

The question at hand was, if there were changes in the eligibility requirements as proposed in the reform legislation, wouldn't it also be feasible to assist the Government in obtaining funds for the cost of care provided under certain catastrophic or other types of conditions.

Mr. MOLINARI. Well, what I'm referring to, and I think maybe you're also referring to in your legislation—we won't know until we see it is that—we have a DOD designated facility in my district, its officials and they don't understand why it is that they are not permitted—of course, they apparently lack the legislative authority to do so—to bill those who have third party coverage. They treat them and they're paid, they do have independent coverage, but they don't reimburse DOD.

It seems to me that, in looking at the budget problems that we have, that is something we should have a better handle on and get some idea as to what kind of revenue we might get. If the coverage is there, I don't know why we don't seek to collect it.

Mr. HAMMERSCHMIDT. Will the gentleman yield?

Mr. MOLINARI. I would be happy to yield.

Mr. HAMMERSCHMIDT. On that subject, Dr. Ditzler, are there legal or constitutional problems with that proposal?

Dr. DITZLER. I would have to defer to legal counsel as to whether there are legal problems. At the moment, my understanding is that most third party insurance coverage carried by a beneficiary has a specification that denies the right to pay if the veteran is being cared for in a VA hospital.

Mr. MOLINARI. Well, I was referring to those in DOD facilities, and I guess we can't get the answer today. But I'll tell you, I would very much appreciate it if you could get back to your counsel or anybody else within the VA to give us an idea as to what revenue projections we could expect if we introduced such legislation, or if you submitted it.

Dr. DITZLER. We will be submitting a legislative proposal and I would anticipate that we would have an estimate in that proposal, sir.

Mr. MOLINARI. Thank you very much.

I thank the gentleman for yielding.

Mr. EDGAR. Thank you.

I yield to my colleague, Mr. Evans, and note that a rollcall vote will, in fact, be taking place. When the next bells ring, we will recess for 10 minutes.

MEANS TEST

Mr. EVANS. Thank you, Mr. Chairman.

I don't know if you have started work on what this means test is going to be. You say you will be proposing legislation to establish a "means test."

Could you give me any idea how this means test would effect a 45-year-old United Auto Worker in my district who might be unemployed. We have 17 to 20 percent unemployment. He may have a late year model car or may have a home with significant equity. Are you going to be basing that means test on income, or on assets as well as income?

Dr. DITZLER. I would like to refer again to my opening statement in which the purpose of the proposed legislation is to ensure that we have the capability of providing quality care to the highest priority veteran, which is the service-connected veteran, and that we

remain capable also of providing quality care to all veterans who cannot afford to pay.

Mr. EVANS. All right. But do you have any idea what the "means test" will mean for a veteran with a non-service-connected problem—and I assume that's where you're going to impose the means test. Will they have to spend down a lot of their assets like they have to do to receive public aid? Are you going to be requiring that?

I have a situation, a very common situation, where people who have earned a lot of money while they were employed, but who have been laid off for maybe 1 year, 1½ year, are no longer entitled to their union-contracted medical care. We're getting a lot of people flooding the veterans' facilities at Iowa City and Danville because of this problem.

What will the "means test" mean to those veterans with significant assets such as an expensive late model car? Would they have to sell their car to become eligible for the medical care that they might need or for a catastrophic illness that they might have? Do you have any idea what that "means test" will mean for those low-income veterans who have those kinds of assets? Are they going to have to spend down those kinds of assets to qualify for medical care from the VA for nonservice-connected problems?

Dr. DITZLER. Let me only say—and I would ask Miss Quandt to address the issue more specifically—that these are items that are going to be in the legislative proposal in considerably more detail. I am sure these issues will be revisited many times as a result of the input we receive from many sources, such as your committee.

Miss Quandt, would you care to offer a comment?

Miss QUANDT. I would simply answer, on the basis of that hypothetical problem, if that veteran has been out of work and unable to show us an annual income, we have not at any time in the Veterans' Administration required that a veteran sell his home or his car, nor would we propose that a veteran sell his place of residence or car.

Mr. EVANS. He might need it to get to your hospitals.

What I'm trying to say is that we have this phenomenon of formerly working people who maybe on a balance sheet have a lot of assets, but who are cash poor in the sense that they don't have any income. Or perhaps unemployment compensation is their only income. I hope you will consider that.

I am not in favor of the "means test," but if you're going to come up with one, I would hope you consider the phenomenon—which I think is a growing phenomenon—of people previously somewhat affluent becoming rather poor overnight.

Thank you, Mr. Chairman.

EMPLOYMENT LEVELS

Mr. EDGAR. Let me just take 30 seconds on my original concern about the jobs, and then I'll put that aside.

It seems to me the bottom line of what I was asking is that, according to the budget proposal that shows 199 new employees being requested in the budget, it is really a fabrication because there is a reduction of 2,092 employees or more from the number that we ac-

tually gave you this year. So it looks like an increase in employment when, in fact, it's a decrease in the numbers of persons that we already authorized and appropriated for the VA to service. Is that correct?

Dr. DITZLER. Reducing the 2,092 now makes it easier for us to get into 1986 with a planned employment level of 192,048 FTEE

[NOTE.—The Veterans' Administration subsequently provided the following information:]

The Medical Care employment through the first quarter of 1985 was 190,482 and provided more care than was planned. Therefore, employment is not being reduced from our present VA strength.

Mr. EDGAR. Let's recess for ten minutes.

[Whereupon, the subcommittee was in recess.]

REPROGRAMMING OF FUNDS

Mr. EDGAR. The subcommittee will come to order. I appreciate everybody's patience and tolerance.

One further question on the employee issue which has been raised. Dr. Ditzler, has the VA requested of the Appropriations Committee a reprogramming of funds because of the lack of enforcement of the employment ceilings that we were mandating?

Dr. DITZLER. No, we have not, sir.

Mr. EDGAR. Does the VA intend to do that, in compliance with the law?

Dr. DITZLER. Mr. Travers.

Mr. TRAVERS. We have been talking this over, sir. We have not decided if we do need a reprogramming. We are looking at it right now.

Mr. EDGAR. It would be helpful if you would inform this committee as to what your final outcome is, because it looks to us as though we had put in place a certain level of funding for the anticipated estimate of care that you had given to us as being projections for both acute care and outpatient clinic care, and it looks, from our vantage point, as though you're understaffing by almost 2,000 persons that particular line item. If, in fact, you are reprogramming that commitment in some way, I think that it's appropriate for you to indicate that to the Appropriations Committee, to the authorizing committee and to the appropriate committees of the Senate. Please let us know what your plan is in that area.

Mr. TRAVERS. We will, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

In FY 1985 the employment reduction is a result of an absorption of a portion of the Agency's estimated personal service supplemental requirements.

Some redistribution of objects of expense are also planned to meet the total expected appropriation level (as passed plus the $72,524,000 supplemental); this type of redistribution does not specifically constitute a reprogramming. We do not anticipate initiating a formal request for reprogramming. The reduced level of 1985 (jurisdictional) employment of 191,849 FTEE provides a manageable transition in employment levels to accommodate the expected level of employment of 192,048 FTEE (jurisdictional) in 1986. This reduction will maintain the 1985 workload level and provide a balanced program.

Mr. EDGAR. I yield to my colleague, Mr. Hammerschmidt, for a round of questions.

MEANS TEST

Mr. HAMMERSCHMIDT. Dr. Ditzler, I want to continue the line of questioning that Mr. Evans was on when we recessed. In your statement you first spoke of VA legislative initiatives. First I will ask you about the means test.

I am concerned about the cost of administering such a test and about the possibility that it won't save much, if any, money. How many people and how much money will it take in fiscal 1986 and then, in subsequent years, to do the administrative things necessary to have a means test?

What is the purpose of the means test? Is it to save money, or to open up possibilities for space available care for less affluent veterans who are now being turned away?

Will the means test actually save any money, and if so, does this budget reflect any such savings?

Dr. DITZLER. I'll try to cover all of those, sir.

Mr. HAMMERSCHMIDT. I'll go back over them if you want me to.

Dr. DITZLER. I would first like to point out that we really do not have finite figures and probably won't for a while. It is fair, however, to say that in the 1986 budget we show no dollar effect, pro or con, relative to a means test.

The purpose, again, I think is to put ourselves in a position where we can guarantee the quality of care that we would like to provide to the highest priority veterans, which in our own minds are the service-connected and those who simply cannot afford medical care. We wish to guarantee access to our facilities for that group in particular.

Mr. HAMMERSCHMIDT. May I ask specifically—and I think you responded to that already—but let me ask you again for the record: Who would be covered by the means test and who would be excluded?

Dr. DITZLER. That is under review as we develop the proposed legislation. Clearly, we would exempt service-connected veterans from the means test. We clearly would have to provide for those we are required and mandated by law to care for in one fashion or another, such as the atomic veterans and the veterans of Vietnam with Agent Orange concerns. Those would clearly be exempted. The remainder is still part of the legislative package currently under consideration, sir.

Mr. HAMMERSCHMIDT. Are you far enough along in your examination of that to tell us how many veterans over age 65 you would contemplate would be kept out of VA hospitals by using the means test?

Dr. DITZLER. I do not believe we have the data on that. We are approaching it more in a context of fairness. We would not wish to keep out of the hospital a poor veteran who needed care but who was displaced, if you will, by a veteran who could afford care simply because he was over 65 years old.

Mr. HAMMERSCHMIDT. You know, we see in news stories—in fact, they're fairly widespread—about free care for veterans over age 65. Those stories would imply that these veterans are sometimes affluent. I wonder if you would please comment on VA's experience in this area.

Dr. DITZLER. I really can't comment very intelligently, except that I hear the same stories. To what extent they are true, I am unprepared to answer.

Miss Quandt, do you have a specific answer as to how many are affluent?

Miss QUANDT. I do not, Dr. Ditzler. If we may, we would like to supply for the record what we know to be income figures by age groups.[1]

Mr. HAMMERSCHMIDT. Fine. We would appreciate that for the record, if you could supply us whatever information you have.

Dr. Ditzler, let me change the subject. Are you contemplating any further contracting out proposals for the Department of Medicine and Surgery?

CONTRACTING OUT (A-76)

Dr. DITZLER. I would presume you are referring contracting out of direct medical care services provided at VA facilities?

Mr. HAMMERSCHMIDT. Yes.

Dr. DITZLER. First of all, let me say that we plan no policy change from those of my predecessor. We are involved in studies of some of our services, and we will be happy to supply for the record the dates and times that we will be initiating these studies.[2] But at the moment, the plan to contract, no. The answer is none.

Mr. HAMMERSCHMIDT. We would appreciate very much having that for the record.

Dr. DITZLER. We would be happy to do so.

Mr. EDGAR. Would the gentleman yield?

Mr. HAMMERSCHMIDT. I yield to the chairman.

Mr. EDGAR. Also for the record, if you would give us a list of those positions that you believe ought to be considered under the A-76 Circular for contracting out of the VA which are in your mind nonmedical in nature.[3]

Dr. DITZLER. I would be happy to do that, sir.

Mr. EDGAR. Thank you.

Dr. Rowland?

INSURANCE COMPANY COLLECTIONS

Dr. ROWLAND. Thank you, Mr. Chairman.

What sort of response have you had from insurance companies about the plans to collect on insurance, and how do you plan to circumvent the exclusionary clause that appears in so many policies?

Dr. DITZLER. At the moment that's in the hands of legal counsel. My own knowledge is based on what I read in the papers. The insurance industry is taking out full page ads objecting to being taxed, and I would suspect a similar response to this proposal. But other than that, I have no first hand knowledge.

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[1] See p. 100.
[2] See p. 37.
[3] See p. 93.

Dr. ROWLAND. So we just don't have any idea at this time on how to collect from private insurance companies for veterans treated in VA facilities and what the reaction might be?

Dr. DITZLER. They might not be happy, but that's a supposition and a personal observation.

MEDICARE ELIGIBILITY

Dr. ROWLAND. Do you have any idea about how many of these veterans who are now receiving care at the VA might go to Medicare or Medicaid to get their care, and what sort of budgetary offset there might be with reference to that?

Dr. DITZLER. Sir, this is a large demographic problem. There are over 28 million veterans. Yet we know that in any given year we are probably seeing no more than 3 to 4 million individual veterans. Obviously, there are 24 million veterans out there right now presumably getting care in other sectors.

We know that a considerable number of them are over 65. Whether they're receiving no care or receiving care in the private sector is not clear, but we presume that a large number of them are already covered and being cared for under the Medicare program.

The problem in projecting our relative share, if you will, hinges on what the Congress eventually does with recommendations relative to Medicare. I have no idea, sir. But part of our projection problem relates to what will and will not be the role of Medicare.

Dr. ROWLAND. If these proposals to restrict eligibility result in a shift out of the VA caring for these patients into another sector, would the VA prefer to keep these patients in the VA? If you lose a lot of patients, you may lose, for example, research grants and things of this nature.

Dr. DITZLER. Speaking as a physician, sir, I think the patient should have the opportunity of choice. If the veteran chooses to come to the Veterans' Administration, I would welcome him. But, on the other hand, it should be his choice.

I think the VA is a quality care system, which I would like to maintain so veterans would want to come to us because of our quality.

Dr. ROWLAND. And if we lose patients from the VA, we may lose the ability to provide some quality?

Dr. DITZLER. It depends on the volume. If you are going to provide certain capabilities, you must have an appropriate milieu and mix of cases in order to guarantee this quality on a 365-day basis.

Dr. ROWLAND. Thank you, Mr. Chairman.

Mr. EDGAR. Thank you.

MEDICAL CONSTRUCTION

Dr. Ditzler, let me shift the discussion just for a few moments to the medical construction part of the budget which has been reduced significantly from previous years. As I understand it—and you correct me if I'm wrong—when the VA prepared its first line budget to send to the Office of Management and Budget, was it not true that there were five hospitals recommended for major construction?

Dr. DITZLER. Not having been here at the time, I will speak indirectly. I do know that we have had a projection of five major projects per year for the next several years. This, I am sure, had all been submitted.

Mr. EDGAR. Wasn't it also true that the Office of Management and Budget came back and said that they believed that two of those projects could, in fact, be funded in 1986?

Dr. DITZLER. I believe that in the initial passback discussions that was correct, but that subsequently has been changed to three.

Mr. EDGAR. Now, in changing that to three, is it correct that the President placed in his budget three hospitals—Houston, TX, Mountain Home, TN, and Philadelphia, PA—for major construction?

Dr. DITZLER. That is correct.

Mr. EDGAR. Can you tell me, sir, why the Mountain Home facility was funded at 100 percent of its request, the Houston project was funded at 84 percent of its request, and the Philadelphia facility was funded at 11 percent of its request?

Dr. DITZLER. My observation, sir, would be that the first two were in priority, as submitted a year ago.

There was an effort, also, to extend our construction efforts and that's how Philadelphia got into it.

Mr. EDGAR. You mentioned that Houston and Mountain Home were top priority a year ago. Do you have documentation on that?

Dr. DITZLER. I would have to turn to my staff, sir.

Dr. GRONVALL. Yes. In the documents that we have submitted, particularly the list of 10, Houston and Mountain Home were at the top of the list of 10 projects.

[Subsequently, the Veterans' Administration furnished the following information:]

LIST OF MEDICAL CENTERS CURRENTLY JUDGED IN NEED OF CONSTRUCTION, REPLACEMENT, OR MAJOR MODERNIZATION

1. Houston, Texas.
2. Allen Park, Michigan.
3. Mountain Home, Tennessee.
4. Pittsburgh (Aspinwall Division), Pennsylvania.
5. Augusta (Uptown Division), Georgia.
6. Gainsville, Florida.
7. Baltimore (Loch Raven), Maryland.
8. Florida-Palm Beach County.
9. Philadelphia, Pennsylvania.
10. Dallas, Texas.

Mr. EDGAR. Do you have the documents here that list those as the 10?

Dr. GRONVALL. No, I'm sorry, I don't. We submit, as you know, the 5-year needs assessment and then, in addition, within that there is a list of the top 10 priorities.

Mr. EDGAR. Can you identify why, if it's accurate that Houston and Philadelphia have approximately the same number of veterans to be served, and Houston and Philadelphia have approximately the same age of facility to be replaced or modernized, why Houston received a higher priority rating than Philadelphia?

Dr. GRONVALL. Let me respond, Mr. Chairman, in a general way rather than specifically. Factors of the Houston project or the

Philadelphia project, could be submitted for the record. But as a generalization, we have many projects that are in the planning pipeline. Each of those projects is assessed on the basis of many criteria: to review its needs, the scope of the project, the proposed timing, other factors such as patient safety, quality of care issues, and a priority scheme is created that is the derivative of considering many factors. Projects then are lined up in order based on a series of judgments as to how those priorities relate; one of the impacts, also, is that they are then placed in line in terms of the years in which they will be built. It is out of that kind of deliberation that the list of 10 is created, which in turn gets converted to year-by-year project submissions for construction.

Mr. EDGAR. Can you tell me why, on the Houston project, after we funded at 84 percent funding in 1986 in the President's budget, they list for 1986, on page 13-85, of the President's budget submission that Houston will have unobligated appropriations at the end of 1986 of $189,310,000.

Dr. GRONVALL. I can't speak to that. Mr. Falco is here. I don't know whether he would be able to address that question or not.

Mr. EDGAR. Please come up and identify yourself at a microphone.

Dr. DITZLER. The gentleman's name is Richard Falco, who represents the Facility Planning and Engineering Service.

Mr. FALCO. Our schedules show that we would, in fact, move forward to make an obligation of the money. As the rules are laid out, we must have the money in hand before we can move forward. It takes several months to do this. We probably will be moving forward at the end of the fiscal year and the award will be made very soon into the following year. By getting this money in the 1986 budget, it will allow us to improve several months on the schedule.

Mr. EDGAR. Let me ask you a question.

In terms of the design phase of the Houston facility, at what stage of the process is the design for that facility?

Mr. FALCO. Well, we're in working drawings right now. We expect to finish the working drawings in the next several months. The bid time for such a large project is over several months so the contractors can amass the information necessary to submit their bids.

Mr. EDGAR. So you anticipate the design phase will be ended at what time?

Mr. FALCO. The design phase is expected to be completed somewhere in the middle of fiscal year 1986.

Mr. EDGAR. Fiscal year 1986?

Mr. FALCO. Right. Then we would be looking to make a construction award.

Mr. EDGAR. Can you make a comparison on the Philadelphia design in terms of when its design phase will be completed and ready to obligate funds for construction?

Mr. FALCO. They are very, very close in schedule. I can furnish that to you for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

The Philadelphia project is being developed in three phases. The design completion of Phase I is scheduled for September 1985, Phase II, December 1985, and the

design for Phase III in November 1986. The design phase for the Houston project will be completed in September 1986, with work on the construction foundation scheduled for March 1986.

Mr. EDGAR. How close?

Mr. FALCO. I really don't know.

Mr. EDGAR. Isn't it true that the Philadelphia schedule is a little bit ahead of the Houston schedule because——

Mr. FALCO. That may be.

Mr. EDGAR. There are four major components of the Philadelphia facility—the 240-bed nursing home, a parking facility, a new outpatient clinic replacing the outpatient clinic which is now housed in a building that is over 80 years of age, and some major renovations of a 1951 facility to bring it up to some health standards that would more adequately relate to the quality of health care issues that this committee has addressed.

Can you or anyone on the panel tell me why the decision was made to put off that renovation but, in a sense, given the budget concerns, moved ahead or accelerated the replacement of the Houston facility?

Mr. FALCO. Well, I think your assumption that we're accelerating the Houston facility at the expense of Philadelphia is not really an accurate appraisal of the situation.

We had been moving forward on the Houston job for the last several years and we have been on record that it is our highest priority from the point of view of getting that hospital replaced.

Mr. EDGAR. What's the age of the existing hospital in Houston?

Mr. FALCO. The Houston hospital has several components; some were built as early as 1930. Now, there is a 1950 bed building there, too, whereas the Philadelphia hospital, as a total facility, was built in 1951. So the Houston hospital is, in fact, a lot older. Several of the components there are still in old World War II barracks with large open wards. I am sure if you saw the Philadelphia bed space and you saw the Houston bed space that you would quickly come to the conclusion that Houston is in greater need of replacement than Philadelphia. That is the VA's position.

Mr. EDGAR. What is the level of excess beds in the general hospital area in the Houston area?

Mr. FALCO. Well, I'm not exactly sure about excess beds in the Houston area, but the VA keys in on beds we need to take care of the veterans. The community beds aren't really a major factor in deciding how many beds we need to take care of the veterans. The size of the Houston hospital is consistent with how we size all VA hospitals, and that, for the most part, doesn't get impacted upon by available community beds.

Mr. EDGAR. But using that argument, we haven't sized the Philadelphia facility based on that. We have simply decided to renovate that facility and save the Federal Government some money.

Mr. FALCO. I think that the Philadelphia hospital has been posed in the exact same way as the Houston hospital, except that the architectural solution in Philadelphia called for modernization of the 1950 building and a major clinical expansion. Houston's bed space is very old and their clinical space is also deficient. There the architectural solution for Houston called for a total replacement. But

the sense of what the VA needed to do was identical in both places. It's just that the best architectural solution is different.

Mr. EDGAR. Could you indicate why the incremental construction of Houston, if they are, indeed, going to wait until the end of 1986, could not have had a lower funding for fiscal year 1986 and a higher funding for fiscal year 1987 and share some of that with the Philadelphia facility in order to keep both hospitals on track and on line?

Mr. FALCO. We think that's exactly what we did. Evidently we didn't do it to a satisfactory level, just from your question.

But what we basically did was attempt to get as much construction as we possibly could moving forward under a Presidential initiative that called for a freeze in the size of the construction program. What we attempted to do was to move forward with our highest priority projects and get as many moving forward as we possibly could. The compromise that I think you see was that we could get nursing home beds available in Philadelphia more quickly under the compromise that was struck. We were not inconsistent with the fact that Houston was a higher priority than Philadelphia.

[NOTE.—The Veterans' Administration subsequently provided the following information:]

Both hospitals are on track and, by the nature of the type of construction, have phases for which separate funding can be requested.

Mr. EDGAR. According to Mr. Boland, who is the Chair of the Appropriations HUD—Independ Agencies Subcommittee, in listening to testimony last year, when the conflict came up between Philadelphia and Baltimore and some of the other facilities, there was testimony given and statements made by the chairman of that Appropriations Subcommittee that Philadelphia, because of its need to modernize its existing facility, did, in fact, in his mind, have a very high priority. That's why he reinstated the $17.7 million of planning and design funds to move that project along, while resisting some efforts from other communities to include additional design funds for other hospital facilities.

Is there a list of criteria around which you determined which communities, in fact, have a more viable need?

Mr. FALCO. Well, I want to take a moment to talk about the fact that the Philadelphia project is a very, very high priority project within the VA. The task at hand was to try to take our highest priority projects and move forward with as many as we possibly could. We do, in fact, have a system to prioritize construction projects. The prioritization system isn't predicated on community kinds of activities. The system is predicated on the need to take corrective action in the medical centers.

So we have, in fact, looked at all the medical centers. The Houston project has been on the list of 10 ever since we were called upon to make a list of 10. It has been the highest priority for the last several years. We have been criticized for not moving forward as quickly as some people would have liked; because the job was so large it was pushed back, to 1986.

I don't want to create the impression that Philadelphia is not in a great need. I don't want to create the impression that Philadel-

phia isn't a higher priority. But I feel obligated to say that the Houston project is of a higher order of priority than the Philadelphia project. We have been saying that for the last several years and this budget reflects that sense of priority.

Mr. EDGAR. Two final questions, very quickly.

Is there a reason why in the outyears there isn't an indication clearly in the budget submission as to whether or not the administration is prepared in 1987 and 1988 to complete the Philadelphia project?

Dr. DITZLER. I think maybe I should answer that, sir.

I think the clear intention of the present budget for 1986 is to view 1986 in a very circumspect fashion and put little or no long-range confidence in the outyear figures.

Mr. EDGAR. So you can't guarantee us today that, if the President's budget is moved and $12 million is committed to Philadelphia and we build the nursing home, build the parking facility, that there's any assurance that in '87 or '88 the very needed clinical improvements and outpatient care improvements will, in fact, be moved on if the President's budget submission is kept?

Dr. DITZLER. I didn't mean to convey that, sir. The 1986 budget proposes to complete the funding of the Philadelphia project in 1987. When we begin a project of the high priority described for Philadelphia, we certainly wouldn't leave it hanging. We would keep going.

[NOTE.—The Veterans' Administration subsequently provided the following information:]

The above statement of Dr. Ditzler is documented in Part 5 of the President's Budget.

Mr. EDGAR. Let me ask one final question, then.

If funding is made available to fully fund the Philadelphia project as one of the high priority projects with Houston and Mountain Home, is that project ready to proceed in fiscal 1986 in the same cycle that we had intended 6 months ago?

Mr. FALCO. If this money was available, we could move forward.

Mr. EDGAR. Thank you.

I yield to my colleague, Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Mr. Chairman, I have a 12 noon commitment, and in view of the fact that Dr. Ditzler will be back up here appearing before the full committee, as will the Administrator, I think I will forego any further questioning and save it for that time, if I may.

Mr. EDGAR. Thank you. We will have ample opportunity at that time.

Let me yield to Miss Kaptur.

Miss KAPTUR. Thank you, Mr. Chairman.

Dr. Ditzler, I had several questions here. First I want to start with my own district because I'm trying to understand how the budget that is being proposed will affect service, specifically in an outpatient clinic that has approximately 30,000 outpatient visits per year in the greater Toledo area, in northwestern Ohio.

Last September we held a committee hearing there, attended by several hundred veterans, because we are in a situation where we have a satellite clinic that is essentially parented with Ann Arbor,

Mich., and our directives and so forth come from there. A lot of problems have been raised over the years.

At the time of the hearing, in trying to work with the medical people at the VA in Ann Arbor, they were very interested in providing us with better medical services and decided that, based on the need, they would assign someone to come down from Ann Arbor 1 day a week to operate a cardiology clinic. Cardiology was one area where they felt there were unanswered needs and where we could save money on transportation costs and so forth, rather than having all these veterans driving up 1 hour north of us.

Two other areas have not been dealt with and I was going to ask your help, in getting back to me by letter perhaps, explaining what the policy of your department really is in regards to the provision of medical services to our clinic in the area of ears, nose and throat—that was one area where we needed additional care—and second, in dermatology. We haven't been able to really get any clear indication from your Department on that.

MEDICAL SCHOOL AFFILIATIONS

Second, beyond those services, there is a real question—all of us are trying to find ways to save money and to deal with the long-term deficit that we face. One of the issues that came up at our hearing was the connection between the VA in our region and the University of Michigan. Right across the street from our veterans satellite clinic in Toledo, Ohio we have a branch of the Medical College of Ohio. One of the things that we were able to do through the VA—and this has been a fairly recent development—we were able to work up an agreement for a dental clinic, so that our veterans would not have to go up to Ann Arbor but they could use the Medical College of Ohio residents and the facilities there. We have had that kind of contractual arrangement.

We are very interested in expanding that to other medical service areas. I have written the VA and received a reply back as to the type of additional contracting that we might do with the Medical College of Ohio as opposed to the University of Michigan. There's a little bit of precedent, as I mentioned, in the dental area.

I wasn't too pleased with the reply. Basically the VA just answered back and said we only affiliate with one hospital as a general rule. Well, we know in places around the country like here in Washington we do have affiliations with more than one. In a special situation like there, where you do have a geographic problem involved, I would be very much interested in your staff taking a personal look at—in addition to working with the Ann Arbor people—to look at the kinds of additional contracts that we might be able to forge with our Medical College of Ohio in order to try to cut costs, give us greater residency people from the medical college there, so we can expand the services to our veterans.

Our clinic, according to VA staffing guidelines, is understaffed by 15 full-time employees. One of the things I would very much appreciate from you and your staff, by letter, would be an explanation of how your budget restraints and some of the cutbacks that are talked about here are going to affect staffing at our clinic, because we have never been able to get the staffing that we need. If we

can't go the contract route to get greater residency participation offering health care from our adjacent medical college, I really don't know what other alternatives we have. So I would like some specific attention directed to our clinic, if I might.

I know you can't answer those things because you have a lot of clinics around the United States.

CLINICS AND HOSPITAL AFFILIATIONS

I think part of the question is going to revolve around the proposals in the 1986 budget, as to the total workload of all of our clinics and all of our hospitals. That becomes one issue.

I think a second issue of whether one contracts with more or less affiliated institutions is a policy that is more recent. That's why perhaps in Toledo's case there is only one affiliation, the University of Michigan. Historically, it is correct that some of our older institutions created some time ago had multiple affiliation arrangements.

This raises the question? Is it cost-effective or not. My own view is that if it's a cost-effective arrangement, we probably could work out some sharing arrangement. One of the problems, however, is that academic medicine is also looking for additional resources, If we have to fund the residents and provide the residents—we are already handicapped in the system as a whole. So it's a question of robbing Peter to pay Paul under those circumstances.

We will look into it and, provide you a satisfactory response.

Miss KAPTUR. One of the things I would truly appreciate, because I've never been able to get it written down on paper, because we are lumped in with the medical and surgical budget up there in Ann Arbor, I truly do not know accurately the full-time equivalent staff in the various categories, both medical and then the administrative staff that are assigned to our clinic. It's very unclear. It has been very difficult.

First of all, we had to break our way into the MEDIPP process, so now at least we're participating for the future. But to try to figure out where we stand right now, even after the excellent hearings that we had, is quite a task. I would certainly love to know exactly what portion of the Ann Arbor budget is specifically in the medical, in the area you cover, directed toward our clinic. We would love to, beyond that, work with you to set cost-effective ways of getting additional residents to provide some of these services in working with our local medical college.

Dr. DITZLER. Thank you for bringing that to our attention.

OUTPATIENT WORKLOADS

[Subsequently, the Veterans Administration furnished the following information:]

As of February 15, 1985, the number of staff authorized for the operation of the Toledo Outpatient Clinic totals 49.575 full-time equivalent employees (FTEE). This level of staffing provides employment for approximately 59 individuals. An additional 16.8 FTEE provide support for the clinic, but are located at the Ann Arbor VA Medical Center. Therefore, the total employment level for the Toledo Outpatient Clinic is presently 66.375 FTEE.

The FY 85 budget for the clinic is approximately $2,676,000, plus $507,000 for salaries associated with the support personnel at VAMC Ann Arbor, for a total budget of $3,183,000.

Miss KAPTUR. Moving away for a moment from my own little area, what is the increase in outpatient visits provided for in the fiscal year 1986 budget?

Dr. DITZLER. Overall, we're talking about a net increase of probably 112,000. That's a net figure, activation of new facilities will add 166,000 while conversion of acute beds to long-term care will result in a decrease of 46,000 staff outpatient visits.

Miss KAPTUR. And if you were to average that out over facilities across the country, that's just a couple of patients a day, is it not?

Dr. DITZLER. Well, it is difficult to average it out because some of our facilities are at a standstill or even declining, while others are greatly accelerating. So to average it out doesn't provide a complete picture of the country.

GS 11–15 GRADE REDUCTIONS

Miss KAPTUR. Ours is greater than that.

I wanted to know, also, what will be the net loss of your medical and surgical personnel with the fiscal years 1986 GS–11 to 15 grade reduction program.

Dr. DITZLER. That's a tough one to answer, primarily because title 38 employees have been excluded. We're dealing with only title 5, the GS grade level series. Activation of clinics in 1985 and 1986, which will require GS–11 to 15 people. In fact, one could project that we might even have more GS–11 to 15's on board. Although we are not supposed to be striving in that direction, we have to have the talents of that type of person.

Miss KAPTUR. So at this time you're not really certains——

Dr. DITZLER. We can supply for the record information we have, but this is a changing picture. Which depends on the hiring practices of our facilities.

Miss KAPTUR. When might we expect to receive that information?

Dr. DITZLER. As soon as we have it. It is difficult to obtain. As of a week ago, we had 200 more GS–11 to 15's on board. Part of that, as I say, is the activation of new clinics.

[Subsequently, the Veterans Administration furnished the following information:]

As of December 31, 1984, the Department must reduce 544 positions before September 30, 1985, to achieve its FY 1985 grade 11–15 ceiling of 15,327. In FY 1986, the Department will have to reduce approximately 306 additional Title 5 GS/GM 11–15 positions.

AVERAGE OPERATING BEDS

Miss KAPTUR. Finally, Public Law 97–72 mandates that the VA operate 90,000 hospital and nursing home beds around the country. But in reading your budget documents, it appears that you plan to reduce bed levels below that mandated number.

Could you please explain your plans in that regard?

Dr. DITZLER. The actual figures are very close to 89,100 when you add together in-hospital beds and the nursing home beds, the pool from which the 90,000 is drawn.

We nearly always have several hundred beds out of service during modernization and repairs. It is correct that we are not exactly at 90,000. We are hovering at 89,000-plus.

Mr. EDGAR. Would the gentleman yield?

Does that number include domiciliary care?

Dr. DITZLER. No. My understanding is that only VA nursing homes and VA hospital beds are included. Is that correct, Miss Quandt?

Miss QUANDT. Yes, that's correct.

Mr. EDGAR. Thank you.

Miss KAPTUR. Thank you, Doctor.

Thank you, Mr. Chairman.

Mr. EDGAR. Before yielding to Mr. Penny, let me ask unanimous consent for the record to include the General Accounting Office letter dated October 25, 1984,[1] which listed the FTEE requirements for this year. Second, an excerpt from the VA legislative language from the HUD and Independent Agencies Appropriation Conference Report of June 26, 1984.[2] Third, a telegram from Clarence M. Bacon, National Commander of the American Legion, in reference to the legislative discussion today.[3] And finally, Congressman Jim Florio transmitted to me a letter with questions to you, and I would like to ask unanimous consent that that letter be sent to you and included in the record for your response. Without objection, so ordered.

[The material appears at p. 94.]

READJUSTMENT COUNSELING

Mr. EDGAR. I now yield to Mr. Penny.

Mr. PENNY. Thank you, Mr. Chairman.

I would like to focus on the readjustment counseling program for Vietnam era veterans. First of all, Dr. Ditzler, what is the total funding allocation for the readjustment counseling program for fiscal year 1985?

Dr. DITZLER. Can I supply that for the record?

Mr. PENNY. That would be fine. If you don't have this with you, I would also like to know what you plan to expend in that program in fiscal year 1986. Do you have that with you, or does that have to be supplied for the record as well?

Dr. DITZLER. I think, to be accurate, I would prefer to supply it for the record.

Mr. PENNY. Do you have some kind of a breakdown on how much of that is in-house and how much contract services for fiscal year 1985?

Dr. DITZLER. It is available, and I will supply that also.

Mr. PENNY. Here again you don't have that along with you today?

Mr. EDGAR. Will the gentleman yield?

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[1] See p. 93.
[2] See p. 93.
[3] See p. 93.

Would you also include in your submission how much of the contract authority you plan to use for the readjustment counseling service?

Dr. DITZLER. We will do so.

Mr. EDGAR. Thank you.

Mr. PENNY. I am also interested in staffing levels for the program for each of those fiscal years. You may not have that along today, either.

Dr. DITZLER. Not off the top of my head I don't. I know that 220 additional people were provided in fiscal year 1985.

Mr. PENNY. But you don't know how many are in place yet? You don't know how many of those 220 are actually on the job now?

Dr. DITZLER. No, I do not, sir.

Mr. PENNY. Do you know how many new vet centers or satellite centers were created or are operational now in fiscal year 1985 that were not operating in fiscal year 1984?

Dr. DITZLER. I'm just going to have to supply that for the record sir. My expert isn't here.

Mr. PENNY. I would appreciate that as well, and then an idea of how many additional centers will be created before fiscal year 1985 ends and what your budget calls for in terms of new centers in fiscal year 1986.

Dr. GRONVALL. If I might just make a brief comment, we provided $8.5 million and 220 FTEE additional allocation for additional vet centers in 1985. We are in the process of establishing 52 additional centers with that money, as well as strengthening the staff at existing vet centers. We can supply in a letter more detailed information.

Mr. PENNY. I would like to see specifically just how that is shaking out and what the projections are. My concern is to see that we're coming close to meeting those targets and, given the questions earlier about what's happening with staffing and how things are being shifted around, I just want to see if these programs are affected by those numbers.

Mr. EDGAR. Would the gentleman yield on that?

Mr. PENNY. Yes.

Mr. EDGAR. Do we have your assurances that the commitment of this committee to a 4-year extension of the readjustment counseling center program and the additional staff levels committed to that particular objective, which was the 220, is going to be fully implemented and is not part of the reduction in force or the difference of opinion on how many people can adequately provide service within the medical area?

Dr. DITZLER. Mr. Chairman, we clearly intend to follow the provision of that law. We have budgeted for full program funding through the period legislated.

[Subsequently the Veterans Administration furnished the following information:]

The FY 1985 estimate for the Readjustment Counseling Program is $40,621,000, inclusive of travel and $8,000,000 in funding for fee/contracts. The FY 1986 budget will be the FY 1985 base ($40,621,000) plus any increases for inflation and any pay requirement changes. It is expected that fee counseling contracts during FY 1986 will stay within the FY 1985 limit of $8 million. P.L. 98-371 provided an additional 220 FTEE and funding for augmentation and expansion of the program. This will allow 52 new Vet Centers and Satellites to open in FY 1985, bringing the total

number of conseling facilities to 189. We project that all of the new Vet Centers and Satellites will be fully operational by July 1985. Ten of the new sites are now functioning and 51 persons have been hired under the augmentation/expansion plan. Full utilization of 794 FTEE for this program is anticipated for FY 1986 to support the 189 Vet Centers and Satellites.

Mr. EDGAR. Thank you.

INPATIENT POST-TRAUMATIC STRESS UNITS

Mr. PENNY. I would also like to find out a little bit about the inpatient post-traumatic stress disorder unit. How many are currently operational?

Dr. DITZLER. As of February 1, 1985, 11 units are operational.

Mr. PENNY. What funding level do you have for that program this fiscal year, fiscal year 1985, and the staffing level as well, if you've got both?

Dr. DITZLER. We have provided an additional $2.6 million in 1985.

Mr. PENNY. Do you have the staffing level there?

Dr. DITZLER. I don't have the details of that. We have opened a new center at Cleveland, and we sent 30 people to that center.

Mr. EDGAR. If the gentleman would yield, do you anticipate any additional increase in 1986 in the post-traumatic stress disorder facilities?

Dr. DITZLER. I think in the budget request there is a request for some $5 million to fund this.

Mr. PENNY. Five million new dollars for that?

Dr. DITZLER. That is my understanding. I would have to supply that for the record because I'm not familiar with that program.

[Subsequently, the Veterans Administration furnished the following information:]

In October 1984, 70 FTEE and $2.6 million were distributed to VA medical centers to provide additional support for PTSD programs. Distribution was as follows:

—30 FTEE and $1.4 million were provided to VAMC Cleveland (Brecksville Division) to assist the activation of the National Center for Stress Recovery.

—16 FTEE and $480,000 were provided to assist the activation of two new PTSD programs.

—24 FTEE and $720,000 were provided to augment existing PTSD programs.

The President's 1986 budget contains no additional staff or funds for PTSD programs.

Mr. PENNY. All right. I would appreciate that.

Last but not least—I see my red light just went off——

Mr. EDGAR. I'm sorry. We're on liberal leave.

GRANTS FOR CONSTRUCTION OF STATE HOMES

Mr. PENNY. I see there is a reduced funding level for the State nursing home construction grant program. We did have a backlog there. That's why we bumped that budget up to $35 million per year. My understanding was we were going to try to keep it there until we took care of the backlog.

What does the reduction to $22 million do in terms of taking care of those that are standing waiting?

Dr. DITZLER. I will ask Dr. John Mather to answer this, please.

Dr. MATHER. The $22 million in the budget will continue to allow us to work off the backlog. Part of the problem is that it's a moving

picture. As we work off certain projects, the States, on their own initiatives, send in additional project applications.

At this point in time we have approximately 65 preapplication for projects totaling around $151 million, which we project would take about 5 years to complete. The $22 million in the budget will allow us to complete approximately 13 projects, and then the balance is stretched out over the next 4 years to work out our current backlog.

Mr. EDGAR. Would the gentleman yield at that point for a question?

Mr. PENNY. Yes, I would.

Mr. EDGAR. I think your answer answers the question in terms of the 4 years, working off the backlog, which you clearly stated. Have there been increases in applications filed? Are they continuing to come into your office?

Dr. MATHER. Mr. Chairman, in the past 2 years the increased appropriations we received, engendered a certain amount of interest in the States. I would have to state that we have seen an increase in the number of preapplications coming in, most particularly during the past year.

Mr. EDGAR. Would that change the number of years that you believe you would really work off your backlog, as new additional States put applications in?

Dr. MATHER. Mr. Chairman, it would, and as I mentioned, it is essentially a moving picture. For every new application we receive, we're talking at least 5 years, given the current budget request, before we can get to those particular projects.

Mr. PENNY. Just to restate the response as I understood it, 65 projects are on the waiting list now; we're talking about 4 years just to take care of those projects. So anybody that is coming in at this point in time is talking about being funded no sooner than the fifth year out?

Dr. MATHER. That's correct, Mr. Penny.

Mr. PENNY. And the wait gets longer from there?

Dr. MATHER. That's correct, Mr. Penny.

Mr. EDGAR. Two additional questions in that area.

One is, has Pennsylvania placed an application for its third State veterans home with your office?

Dr. MATHER. Mr. Chairman, we have not received a preapplication for a third state veterans home in Pennsylvania. We have heard strong rumors in the past couple of weeks that we were going to receive a preapplication, but we have not received one.

LEGISLATIVE CHANGE IN THE STATE HOME PROGRAM

Mr. EDGAR. We've had press reports, that the Governor announced the site of the third veterans home, and a great deal of fanfare was around it. The State of Pennsylvania should get its act together.

Let me ask one final question, and that is, the administration is asking for some legislative change in that area of State homes, and I wonder if you would explain to the committee the legislative change that could be helpful in terms of the one-third provision.

Dr. MATHER. Mr. Chairman, we have tried to properly administer the grants program for construction of State home facilities. There is a provision in the law that makes it difficult for us to obligate the money for a whole project. This is known as the one-third rule, where in any one year's appropriation you can only obligate no more than one-third of that appropriation in any one State. Hence, as we fund increasingly more expensive projects, sometimes we have to hold those moneys over between fiscal years in such a way that at the beginning of the next fiscal year we can fully fund these projects, which is also required by law.

We believe at this point in time that some relief from that one-third rule would be very helpful.

THE AGING VETERAN POPLULATION

Mr. EDGAR. Thank you.

Dr. Ditzler, let me turn the attention to just some remaining questions I have in the area of the aging veteran.

Dr. Ditzler, do you believe that the greying of the veteran population necessitates significant emphasis on the field of geriatric medicine? What I am trying to learn is your own personal views as to whether there will be real growth and significant shifts in the needs of veterans using the VA health care system because of age.

Dr. DITZLER. Obviously there are going to be significant changes as we all get older. The question is the extent to which the Veterans' Administration will be obligated in this care.

There needs to be a national policy for the care of the aging population to coincide with what we decide internally, within the VA.

Our ability to poject the availability of private sector nursing home beds in the future is limited. The ability to project the number of veterans over 65 that will or will not utilize a medicare scheme of coverage is a parallel concern. Our ability to plan aggressively within the VA is not only budgetary, but coming to grips with the magnitude of who else within the general population shares in the responsibility.

With respect to research, the type of research that is possible, in large measure, is going forward. The ability to apply what that research tells us, culturally as well as socially and politically, is difficult.

I think we are finding now that, as we look toward the 1987 budget, we are having a hard time in getting answers to those things that need to be decided regarding the aging population. We clearly know that part of the problem also relates to the way we take care of the spouses of veterans. We need to know the issue of transportability away from a given area to which they have long since been accommodated. Many of our aging veterans don't want to leave the community in which they are located, and yet there is no VA facility there.

I think the question is a very broad one. We are struggling with it. We have the special medical advisory group to help us. We have a geriatric advisory group which reports also. They, too, are struggling with the appropriateness and the timeliness of how we're going to approach it.

Fortunately, when we began this project, the concern was for the veteran over 65. We are now beginning to see that although resource consumption does increase for the 65 and older the actual significant increases occur in the 70- and 75-year-olds. We're seeing shifts in the health of the country and the changing technology.

I'm sorry I can't provide a more appropriate answer, but I'm not a geriatrician. I'm just getting old.

VIEWS ON THE AGING REPORT

Mr. EDGAR. In reference to the caring for older veterans report and its analysis of the problem, do you find that report clearly in sync with your views?

Dr. DITZLER. I think the report is excellent, in that it explores all the views. My concern is to the extent on which we can base projections and estimates.

Mr. EDGAR. If I read the report, accurately, and from our 2 years of visits around the country knowing that half of the veteran population by 1990 is going to be over the age of 65. You indicated the fast-growing population sectors, the senior boom above 75 and above 85—and it occurs to me that a response is going to have to be made. You and I have talked in the past and you have indicated again today that there may be multiple factors that will have to be looked at as to how we provide care to that aging population.

My fear, as chairman of this subcommittee, is that if we don't begin to respond soon with creative techniques and methods, some of which are clearly noninstitutional, that we're going to find ourselves with a problem in 1987, 1988, 1989, where there will be an increased emphasis on a means test in cutting certain folks out of the system, rather than the system caring for service-connected veterans and needy veterans and a group of other veterans who have a particular need, we'll see more and more restriction of the system itself.

Are there additional resources requested in the 1986 budget for community nursing home care? Are there additional resources in this budget for adult day health care expansion? Are there additional resources for community residential care expansion? Are there additional resources in this budget for hospital-based home care program expansion? Is there additional funding in this budget for geriatric research, education, and clinic centers expansion? Is there in this 1986 budget any expansion of the geriatric evaluation unit program? Are there funds here for the hospice care program and its expansion? And what about the respite care program and its expansion?

What are your specific proposals in 1986 to begin to deal with the problem of the aging veteran?

Dr. DITZLER. I'm going to ask John Mather to respond in part to that. I think that there are, within this budget, efforts approaching some of the answers. Particularly there are additional funds for community nursing. There will be an expansion of the day health care centers but essentially as an expansion of that which was begun in 1985.

Many of the answers to the other questions are really "No". There are not specific additional budgetary line items for those beyond inflationary increases from the 1985 levels.

Mr. EDGAR. Isn't it also true that there were requests for some of those programs to the Office of Management and Budget by the medical director's office and by the Administrator of the VA?

Dr. DITZLER. John?

Dr. GRONVALL. Yes.

Mr. EDGAR. So that the Office of Management and Budget, in its passback, eliminated from that budget some of the innovative care proposals that have been passed in law and suggested by the chief medical director's office?

Dr. DITZLER. That's correct.

[Note: The Veterans' Administration subsequently added that OMB in its passback stated a willingness to expand these programs after their cost-effectiveness has been determined.]

Mr. EDGAR. Let me ask two final questions and then I will yield to my colleague—do you have additional questions at this point?

Miss KAPTUR. No.

ADEQUACY OF THE 1986 BUDGET

Mr. EDGAR. Let me then close with two questions.

Dr. Ditzler, would you please tell the subcommittee, because this is your first visit, your personal views as a physician, not as chief medical director but as a physician, your personal views as to the adequacy of the 1986 budget in meeting the stated mission of the VA.

Dr. DITZLER. The stated mission of the VA can be met as long as we are able to come to grips with a definition of eligibility and space availability. It has been a problem that has bothered hospital directors and chiefs of staff for years. We know that our priorities apply in descending order. We know we have the highest priority for the service-connected veteran. We know that we have priorities for former prisoners of war, for agent orange exposure, and atomic exposure. All of these are on a descending priority, and on a space available, a facility available basis, and then for everyone else who applies and is an eligible veteran.

This becomes the issue of defining space availability. I can only say that we do the best we can and we usually improve the workload.

The issue before us is to produce a quality product with amount of dollars we have. When one faces the aging population report, I think the proposal that the Administrator will make relative to amending title 38 has, indeed, significance in how we are going to answer your question.

I think the real bottom line is that we have never come to grips, as a hospital director, as a chief of staff, or as a physician out there, with the question of the "space available" issue. If one is going to produce a quality product, then one also has to consider preventive medical care, which is a tough proposition to throw in. That's why I have said on occasions, much to the dismay of colleagues and friends, that in a sense you need an enrollment mechanism, not necessarily to close an enrollment, but at least to match

the number you're going to take care of versus the available dollars.

I'm not sure I've been responsive.

Mr. EDGAR. It is helpful to know your personal views in that area. I happen to agree with you in terms of preventive health care, and that's why I'm so much of an advocate for some of the programs that I listed, particularly in responding to the aging veteran problem. We are not going to be able to deal with that issue and some of the other related issues of health care simply through an institutional setting, and we're going to have to figure out some ways of delivering that service. I am afraid that what I hear the administration stating is that the way we'll handle it is to put a means test on, to lop off even more veterans who are presently receiving care, and figure out a way to make the number of dollars match the number of veterans we want to care for, not necessarily the mission of the VA.

I think that would be a mistake. It would be a mistake in terms of our ability to deliver a quality product. I think it would also be a mistake for our Nation if, in fact, we don't do that with a great deal of care so that, as we remold this VA health care system, we do it in a healthy way.

AUTOMATED DATA PROCESSING

Let me ask you one technical question, and then I want to close with a comment.

On page 4-9, volume II of the submission, it is noted that only $3.1 million is being requested for computer system equipment. This is $14.8 million below the fiscal year 1985 level. Does this mean an additional $3.1 million will complete the procurement of computer systems for all health care delivery facilities? If not, what is the estimated cost for the complete installation for the decentralized hospital computer system throughout the VA facilities? And whose decision was it only to request the $3.1 million in fiscal year 1986?

Dr. DITZLER. I would like to ask Mr. Roger Cooper, my computer specialist, if he would care to address that question.

Mr. COOPER. Mr. Chairman, the $3 million would complete the system as we originally intended the system. As you are probably aware, we have been expanding the scope of Decentralized Hospital Computer Program [DHCP] considerably in the last year or two because of its great success.

I think the problem is defining what you mean by the full implementation of DHCP. We could provide for the record what we talked about in this budget and other budgets and you would be able to see the difficulty in defining it; we have been adding functions daily. But we probably do not have sufficient funding to do all the functions that are envisioned at this point.

Mr. EDGAR. Was your request, in fact, higher than the $3.1 million?

Mr. COOPER. The request from——

Mr. EDGAR. From the VA to the Office of Management and Budget.

Mr. COOPER. I believe it was higher, yes, sir.

Mr. EDGAR. Do you know how much higher?

Mr. COOPER. The particular line items, I believe it was approximately $3 million difference.

Mr. EDGAR. Thank you very much. We would appreciate for the record some additional information.

[Subsequently, the Veterans' Administration furnished the following information:]

The Department of Medicine and Surgery requested an additional $2,936,000 and 45 FTEE for enhancements to DHCP hardware and software. An additional $18,852,000 was requested for local field initiatives and field office automation. The three initiatives were as follows:

DHCP equipment	$2,936,000
DHCP (V&DC FTEE)[1]	(45)
Field office automation	5,584,000
Local field initiatives	13,268,000
Total	$21,788,000

[1] Funding to support the FTEE would have been provided through net reductions in other areas such as equipment maintenance, operating supplies, etc.

Current plans call for the integration of field office automation and local field initiatives into the composition of DHCP. We are currently working to expand the scope of DHCP under the VA Modernization Plan.

What is the fiscal year 1985, 1986 funding level for the integrated hospital computer system?

Mr. COOPER. I believe the funding level is around $8.6 million.

Mr. EDGAR. Can you supply that for the record for us?

Mr. COOPER. Yes, sir.

Mr. EDGAR. Thank you.

[Subsequently, the Veterans' Administration furnished the following information:]

The funding level for the IHS is $6,345,000 for FY 1985 and $8,632,000 for FY 1986.

Dr. Ditzler, let me thank you and your colleagues for coming today. Let me just close with a quote from the Caring for Older Veterans Report.

In that report it states:

The Veterans' Administration stands prepared to meet the real expanding and changing health care needs which result from the aging of the veteran population. It is apparent that in most every case, the largest percentage of veterans using the system were the nearly elderly, those between the ages of 55 and 64. This group constituted 33.3 percent of all institutionalized patients. As this population ages over the next 10 to 15 years and gets sicker and more frail, the proportion of elderly users will increase dramatically throughout the VA health care system.

I share that quote because it is not a quote from Bob Edgar. It is a quote from a report that the VA prepared. Over the course of the next 2 years, as you hear our comments and the concerns of members of this committee about the aging veteran population, it will be based in large part on the very report that was produced by the VA itself. And when we begin to talk about things like home health care and adult day care, respite care, hospice care and some of the other suggestions that we have made, and in some cases put in law, we don't see those programs as being extracurricular, to be used when and if we can get around to them. We see them as a vital and integrated part of the health care delivery network in

providing some preventive health care and some long-term care to our aging veteran population.

In the area of the State veterans' home program, we deliberately increased the funding levels last year, and the per diem rates, so that we could participate with the States in responding to that problem. It is going to be a very high priority of this committee and I look forward to working with you in accomplishing the task of meeting that particular concern in a positive and creative way. It's a big job; it's an important job. It may not need the huge dollar amounts as some might expect if, in fact, we can be creative in the way in which we respond to it. It may have implications in terms of other services of the Federal Government and we look forward to trying to find out what they are.

Thank you for coming early. We will, in fact, have some sharp questions, hopefully, for the Administrator when he comes back to talk about other budget priorities. You have been kind to come and give your views this morning.

Dr. DITZLER. Thank you, Mr. Chairman.

Mr. EDGAR. Thank you.

The committee stands adjourned.

[Whereupon, at 12:30 p.m., the subcommittee adjourned.]

FISCAL YEAR 1986 BUDGET PROPOSAL—VA MEDICAL PROGRAMS

[Dollar amounts in millions]

	1984	1985	1986	Change
Budget authority:				
Medical care	$8,244	$8,854	$9,090	+236
Medical and prosthetic research	218	192	187	−5
Central office (MAMOE)	67	68	56	−12
State Veterans homes grants	18	35	22	−13
Construction	532	768	612	−156
Total	9,078	9,917	9,967	+50
FTEE:				
Medical care	189,865	191,849	192,048	+199
Medical and prosthetic research	4,394	4,505	4,348	−157
Central office (MAMOE)	875	837	753	−84
Construction	861	840	810	−30
Total	195,995	198,031	197,959	−72
Selected work loads provided by VA (millions):				
Inpatients treated	1.412	1.406	1.409	+.003
Outpatient visits	18.597	18.685	18.797	+.112

Key Issues—President's Proposed Fiscal Year 1986 Budget for VA Health Care

*Apply means test to all veterans. (Requires legislation for veterans older than 65).

*Legislation to permit VA to bill private health care insurers except for treatment of service-connected disabilities.

*5% reduction in employee pay.

*Delays in full funding for construction of major replacement/modernization hospitals at Augusta, GA, New York, NY, Houston, TX, and Philadelphia, PA.

*Reduce construction of VA nursing homes. (7 projects planned for FY 1986; 2 funded).

*"Freeze" in number of patients treated; reduction in VA hospital beds and VA staffing; on funds for program improvements (e.g. adult day health care, PTSD units).

*Miscellaneous cuts based on "reductions" in grades GS 11-15, other Grace Commission recommendations.

FTEE

		Start dates[1]
A-76 cost comparison studies (95 VAMC's involved):		
Laundry	1,681	July 1985.
Canteen food	1,261	April 1985.
Warehouse	588	December 1985.
Fire protection	456	September 1985.
Transcription	310	July 1985.
Grounds	259	February 1986.
Chauffeur	208	October 1985.
Switchboard	201	February 1986.
Mail messenger	12	March 1986.
Furniture repair	10	September 1986
Interior design	10	April 1986.
Design-Drafting	10	April 1985.
Data entry	10	May 1986.
Total A-76	5,016	

FTEE--Continued

		Start dates[1]
MEO productivity management studies (158 VAMC's involved):		
Hospital housekeeping	9,892	October 1985.
Dietetics food	9,547	July 1986.
Plant maintenance	2,927	January 1986.
Office operations	1,376	December 1986.
Medical information	580	November 1986.
Total MEO	24,322	
Grand total A-76 and MEO:	29,338	

[1] Studies will take up to 6 months. Results come into CO for review. A-76 studies go from fiscal year 1985-fiscal year 1988; MEO studies from fiscal year 1986-1989.

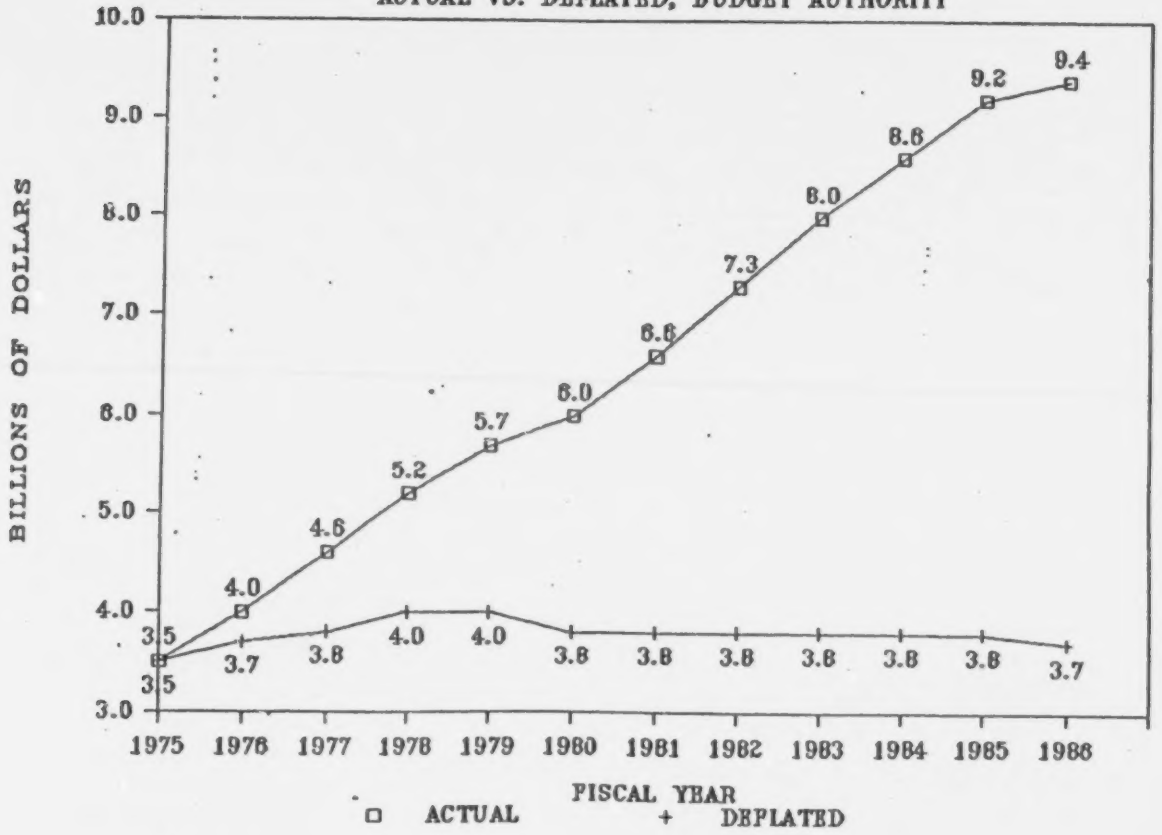
OMB rule of thumb is 20% savings on either type studies (FTEE and dollars). This equates to 1000 FTEE/year over a five year period.

A-76 Cost Comparison Studies

The VA has developed a facility-by-facility management plan to conduct A-76 cost comparison studies. A draft of that plan is appended. It should be noted the dates are not yet set absolutely and a few facilities' specific plans are absent due to reporting errors. We are working to complete the plan and refine the estimated starting dates of studies indicated therein.

ALL MEDICAL PROGRAMS

ACTUAL VS. DEFLATED, BUDGET AUTHORITY



NATIONAL SUMMARY	A-76 Analysis								
	Fiscal Year 1985			Fiscal Year 1986			Fiscal Year 1987		
FUNCTION	STUDIES (#)	FTEE	COST ($000)	STUDIES (#)	FTEE	COST ($000)	STUDIES (#)	FTEE	COST ($000)
CHAUFFEURS	1	18	342	13	200	3800			
DATA/KEYPUNCH				1	10	174			
DESIGN/DRAFTING	11	10	190						
FIRE PROTECTION	19	229	5000	11	164	3109			
FURNITURE REPAIR				1	10	190			
GROUNDS	5	64	1216	16	234	4446			
INTERIOR DESIGN				1	10	174			
LAUNDRY	35	911	17309	28	763	14497			
MAIL-MESSENGER				1	12	209			
PRINT/REPRODUCTION				1	10	174			
SWITCHBOARD	9	101	1797	10	115	2002			
TRANSPORTATION	4	44	804	14	186	3222	5	67	1185
VCS FOOD	43	710	12920	32	549	10431			
WAREHOUSE	12	172	3383	28	371	7049	5	60	1140
TOTALS	129	2259	42961	157	2634	49477	10	127	2325
MAXIMUM	43	911	17309	32	763	14497	5	67	1185
MINIMUM	1	10	190	1	10	174	5	60	1140
AVERAGE	14	251	4773	12	203	3806	5	63	1163
25%		565	10740		658	12369		32	581
50%		1130	21481		1317	24738		63	1163
75%		1694	32221		1975	37108		95	1744

FIRE PROTECTION — REGION #1 — A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985						Fiscal Year 1986						Fiscal Year 1987					
		STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
NORTHAMPTON	1	9/85	2/86	7/86	8/86	12/86	2/87												
BATH	2							12/85	5/86	10/86	11/86	3/87	5/87						
CANANDAIGUA	2							12/85	5/86	10/86	11/86	3/87	5/87						
CASTLE POINT	3							6/85	11/85	4/86	5/86	9/86	11/86						
MONROE	3							6/85	11/85	4/86	5/86	9/86	11/86						
NOR	3							6/85	11/85	4/86	5/86	9/86	11/86						
TOT	DIES							5											

CHAUFFEURS REGION #1 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
BROCKTON	1							5/86	10/86	3/87	4/87	8/87	10/87						
BATH	2							10/85	3/86	8/86	9/86	1/87	3/87						
TOTAL STUDIES								2											

FURNITURE REPAIR REGION #1 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985						Fiscal Year 1986						Fiscal Year 1987					
		STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/ME IMPL
SAN JUAN	3							9/86	2/87	7/87	8/87	12/87	2/88						
TOTAL STUDIES								1											

GROUNDS REGION #1 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
CANANDAIGUA	2							2/86	7/86	12/86	1/87	5/87	7/87						
BROOKLYN	3							2/86	7/86	12/86	1/87	5/87	7/87						
TOTAL STUDIES								2											

REGION #1 A-76 Analysis

LAUNDRY FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
Bedford	1	7/85	12/85	5/86	6/86	10/86	12/86												
Brockton	1	7/85	12/85	5/86	6/86	10/86	12/86												
Northampton	1	7/85	12/85	5/86	6/86	10/86	12/86												
Bath	2	8/85	1/86	6/86	7/86	11/86	1/87												
Buffalo	2	8/85	1/86	6/86	7/86	11/86	1/87												
Canandaigua	2	8/85	1/86	6/86	7/86	11/86	1/87												
Syracuse	2	8/85	1/86	6/86	7/86	11/86	1/87												
Brooklyn	3	9/85	2/86	7/86	8/86	12/86	2/87												
San Juan	3	9/85	2/86	7/86	8/86	12/86	2/87												
West Haven	3	9/85	2/86	7/86	8/86	12/86	2/87												
TOTAL STUDIES		10																	

SWITCHBOARD REGION #1 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/M IMP
BROCKTON	1							2/86	7/86	12/86	1/87	5/87	7/87						
BROOKLYN	3							4/86	9/86	2/87	3/87	7/87	7/87						
NEW YORK	3							4/86	9/86	2/87	3/87	7/87	9/87						
TOTAL STUDIES								3											

WAREHOUSE REGION #1 — A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
BROCKTON	1							12/85	5/86	10/86	11/86	3/87	5/87						
BUFFALO	2							2/86	7/86	12/86	1/87	5/87	7/87						
BROOKLYN	3							11/85	4/86	9/86	10/86	2/87	4/87						
NEW YORK	3							11/85	4/86	9/86	10/86	2/87	4/87						
NORTHPORT	3							11/85	4/86	9/86	10/86	2/87	4/87						
SAN JUAN	3							11/85	4/86	9/86	10/86	2/87	4/87						
WEST HAVEN	3							11/85	4/86	9/86	10/86	2/87	4/87						
TOTAL STUDIES								7											

CHAUFFEURS REGION #2 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/ME IMPL
EAST ORANGE	4							8/86	1/87	6/87	7/87	11/87	1/88						
LYONS	4							8/86	1/87	6/87	7/87	11/87	1/88						
PITTSBURGH (UD)	5							7/86	12/86	5/87	6/87	10/87	12/87						
TOTAL STUDIES								3											

GROUNDS REGION #2 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
COATESVILLE	4							7/86	12/86	5/87	6/87	10/87	12/87						
LEBANON	4							7/86	12/86	5/87	6/87	10/87	12/87						
MOUNTAIN HOME	8							9/86	2/87	7/87	8/87	12/87	2/88						
TOTAL STUDIES								3											

FIRE PROTECTION — REGION #2 — A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
COATESVILLE	4							9/86	2/87	7/87	8/87	12/87	2/88						
LYONS	4							9/86	2/87	7/87	8/87	12/87	2/88						
BUTLER	5	5/85	10/85	3/86	4/86	8/86	10/86												
MARTINSBURG	6							6/86	11/86	4/87	5/87	9/87	11/87						
PERRY POINT	6							11/85	4/86	9/86	10/86	2/87	4/87						
HAMPTON	7							1/86	6/86	11/86	12/86	4/87	6/87						
TOTAL STUDIES		1						5											

LAUNDRY REGION #2 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985						Fiscal Year 1986						Fiscal Year 1987					
		STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
Coatesville	4							1/86	6/86	11/86	12/86	4/87	6/87						
Lebanon	4							1/86	6/86	11/86	12/86	4/87	6/87						
Lyons	4							1/86	6/86	11/86	12/86	4/87	6/87						
Wilkes Barre	4							1/86	6/86	11/86	12/86	4/87	6/87						
Pittsburgh (UD)	5	8/85	1/86	6/86	7/86	11/86	1/87												
Martinsburg	6	4/85	9/85	2/86	3/86	7/86	9/86												
Perry Point	6	4/85	9/85	2/86	3/86	7/86	9/86												
Hampton	7	10/85	3/86	8/86	9/86	1/87	3/87												
Richmond	7	10/85	3/86	8/86	9/86	1/87	3/87												
Salem	7	10/85	3/86	8/86	9/86	1/87	3/87												
Asheville	8	12/85	5/86	10/86	11/86	3/87	5/87												
Mountain Home	8	12/85	5/86	10/86	11/86	3/87	5/87												
Salisbury	8	12/85	5/86	10/86	11/86	3/87	5/87												
TOTAL STUDIES		9						4											

SWITCHBOARD REGION #2 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
EAST ORANGE	4							3/86	8/86	1/87	2/87	6/87	8/87						
WASHINGTON DC	6							6/86	11/86	4/87	5/87	9/87	11/87						
RICHMOND	7							7/86	12/86	5/87	6/87	10/87	12/87						
TOTAL STUDIES								3											

TRANSCRIPTION REGION #2 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985						Fiscal Year 1986						Fiscal Year 1987					
		STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/ME IMPL
PITTSBURGH (UD)	5													10/86	4/87	9/87	10/87	2/88	4/8
RICHMOND	7													11/86	4/87	9/87	10/87	2/88	4/8
SALISBURY	8													10/86	3/87	8/87	9/87	1/88	3/8
TOTAL STUDIES														3					

TRANSCRIPTION REGION #2 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
PITTSBURGH (UD)	5													10/86	4/87	9/87	10/87	2/88	4/88
RICHMOND	7													11/86	4/87	9/87	10/87	2/88	4/88
SALISBURY	8													10/86	3/87	8/87	9/87	1/88	3/88
TOTAL STUDIES														3					

VOID REGION #1 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985						Fiscal Year 1986						Fiscal Year 1987					
		STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/ME IMPL
Coatesville	4							10/85	3/86	8/86	9/86	1/87	3/87						
East Orange	4							10/85	3/86	8/86	9/86	1/87	3/87						
Lyons	4							10/85	3/86	8/86	9/86	1/87	3/87						
Wilkes Barre	4							10/85	3/86	8/86	9/86	1/87	3/87						
Pittsburgh (HD)	5	4/85	9/85	2/86	3/86	7/86	9/86												
Pittsburgh (UD)	5	4/85	9/85	2/86	3/86	7/86	9/86												
Martinsburg	6	9/85	2/86	7/86	8/86	12/86	2/87												
Washington D.C.	6	9/85	2/86	7/86	8/86	12/86	2/87												
Richmond	7	6/85	11/85	5/86	6/86	10/86	12/86												
Salem	7	5/85	10/85	3/86	4/86	8/86	10/86												
Asheville	8	7/85	12/85	5/86	6/86	10/86	12/86												
Fayetteville	8	7/85	12/85	5/86	6/86	10/86	12/86												
Mountain Home	8	7/85	12/85	5/86	6/86	10/86	12/86												
TOTAL STUDIES		9						4											

VCS FOOD · REGION #1 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985						Fiscal Year 1986						Fiscal Year 1987					
		STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
Coatesville	4							10/85	3/86	8/86	9/86	1/87	3/87						
East Orange	4							10/85	3/86	8/86	9/86	1/87	3/87						
Lyons	4							10/85	3/86	8/86	9/86	1/87	3/87						
Wilkes Barre	4							10/85	3/86	8/86	9/86	1/87	3/87						
Pittsburgh (HD)	5	4/85	9/85	2/86	3/86	7/86	9/86												
Pittsburgh (UD)	5	4/85	9/85	2/86	3/86	7/86	9/86												
Martinsburg	6	9/85	2/86	7/86	8/86	12/86	2/87												
Washington D.C.	6	9/85	2/86	7/86	8/86	12/86	2/87												
Richmond	7	6/85	11/85	5/86	6/86	10/86	12/86												
Salem	7	5/85	10/85	3/86	4/86	8/86	10/86												
Asheville	8	7/85	12/85	5/86	6/86	10/86	12/86												
Fayetteville	8	7/85	12/85	5/86	6/86	10/86	12/86												
Mountain Home	8	7/85	12/85	5/86	6/86	10/86	12/86												
TOTAL STUDIES		9						4											

WAREHOUSE REGION #2 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
EAST ORANGE	4							6/86	11/86	4/87	5/87	9/87	11/87						
PITTSBURGH (UD)	5							1/86	6/86	11/86	12/86	4/87	6/87						
WASHINGTON DC	6							9/86	2/87	7/87	8/87	12/87	2/88						
RICHMOND	7							2/86	7/86	12/86	1/87	5/87	7/87						
MOUNTAIN HOME	8							3/86	8/86	1/87	2/87	6/87	8/87						
TOTAL STUDIES								5											

CHAUFFEURS REGION #3 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
MIAMI	12							8/86	1/87	6/87	7/87	11/87	1/88						
LITTLE ROCK	19	8/85	1/86	6/86	7/86	11/86	1/87												
TOTAL STUDIES		1						1											

DESIGN/DRAFTING REGION #3 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
LITTLE ROCK	19	9/85	2/86	7/86	8/86	12/86	2/87												
TOTAL STUDIES		1																	

FIRE PROTECTION REGION #3 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/ME IMPL
TUSKEGEE	10							6/86	11/86	4/87	5/87	9/87	11/87						
MURFREESBORO	11	4/85	9/85	2/86	3/86	7/86	9/86												
ALEXANDRIA	19							11/85	4/86	9/86	10/86	2/87	4/87						
LITTLE ROCK	19							11/85	4/86	9/86	10/86	2/87	4/87						
TOTAL STUDIES		1						3											

GROUNDS REGION #3 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
BILOXI	10							7/86	12/86	5/87	6/87	10/87	12/87						
MURFREESBORO	11							1/86	6/86	11/86	12/86	4/87	6/87						
BAY PINES	12							9/86	2/87	7/87	8/87	12/87	2/88						
TOTAL STUDIES								3											

LAUNDRY REGION #3 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/ME IMPL
AUGUSTA	9							1/86	6/86	11/86	12/86	4/87	6/87						
BILOXI	10							12/85	5/86	10/86	11/86	3/87	5/87						
TUSCALOOSA	10							12/85	5/86	10/86	11/86	3/87	5/87						
TUSKEGEE	10							12/85	5/86	10/86	11/86	3/87	5/87						
LOUISVILLE	11							10/85	3/86	8/86	9/86	1/87	3/87						
MURFREESBORO	11							10/85	3/86	8/86	9/86	1/87	3/87						
BAY PINES	12							3/86	8/86	1/87	2/87	6/87	8/87						
LAKE CITY	12							3/86	8/86	1/87	2/87	6/87	8/87						
MIAMI	12							3/86	8/86	1/87	2/87	6/87	8/87						
ALEXANDRIA	19							3/86	8/86	1/87	2/87	6/87	8/87						
LITTLE ROCK	19							3/86	8/86	1/87	2/87	6/87	8/87						
TOTAL STUDIES								11											

SWITCHBOARD REGION #3 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
AUGUSTA	9							9/86	2/87	7/87	8/87	12/87	2/88						
MEMPHIS	11							6/86	11/86	4/87	5/87	9/87	11/87						
MIAMI	12							6/86	11/86	4/87	5/87	9/87	11/87						
LITTLE ROCK	19	7/85	12/85	5/86	6/86	10/86	12/86												
TOTAL STUDIES		1						3											

FACILITY NAME	DST #	Fiscal Year 1985						Fiscal Year 1986						Fiscal Year 1987					
		STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
TUSKEGEE	10	9/85	2/86	7/86	8/86	12/86	2/87												
LOUISVILLE	11							9/86	2/87	7/87	8/87	12/87	2/88						
NASHVILLE	11							9/86	2/87	7/87	8/87	12/87	2/88						
MIAMI	12							9/86	2/87	7/87	8/87	12/87	2/88						
LITTLE ROCK	19							12/86	5/87	10/87	11/87	3/88	5/88						
NEW ORLEANS	19							12/86	5/87	10/87	11/87	3/88	5/88						
TOTAL STUDIES		1						5											

VCS FOOD REGION #3 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
AUGUSTA	9	8/85	1/86	6/86	7/86	11/86	1/87												
CHARLESTON SC	9	8/85	1/86	6/86	7/86	11/86	1/87												
COLUMBIA SC	9	8/85	1/86	6/86	7/86	11/86	1/87												
ATLANTA(DECATUR)	9	8/85	1/86	6/86	7/86	11/86	1/87												
BILOXI	10	9/85	2/86	7/86	8/86	12/86	2/87												
BIRMINGHAM	10	9/85	2/86	7/86	8/86	12/86	2/87												
JACKSON	10	9/85	2/86	7/86	8/86	12/86	2/87												
LEXINGTON	11							1/86	6/86	11/86	12/86	4/87	6/86						
MEMPHIS	11							1/86	6/86	11/86	12/86	4/87	6/86						
NASHVILLE	11							1/86	6/86	11/86	12/86	4/87	6/86						
BAY PINES	12							1/86	6/86	11/86	12/86	4/87	6/86						
GAINESVILLE	12							1/86	6/86	11/86	12/86	4/87	6/86						
MIAMI	12							1/86	6/86	11/86	12/86	4/87	6/86						
TAMPA	12							1/86	6/86	11/86	12/86	4/87	6/86						
LITTLE ROCK	19							1/86	6/86	11/86	12/86	4/87	6/86						
NEW ORLEANS	19							1/86	6/86	11/86	12/86	4/87	6/86						
TOTAL STUDIES		7						9											

WAREHOUSE REGION #3 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/ME IMPL
AUGUSTA	9							6/86	11/86	4/87	5/87	9/87	11/87						
COLUMBIA SC	9							6/86	11/86	4/87	5/87	9/87	11/87						
BILOXI	9							3/86	8/86	1/87	2/87	6/87	8/87						
TL[illegible]E	9							3/86	8/86	1/87	2/87	6/87	8/87						
LE[illegible]ON	11							3/86	8/86	1/87	2/87	6/87	8/87						
ME[illegible]	11							3/86	8/86	1/87	2/87	6/87	8/87						
ML[illegible]SBORO	11							3/86	8/86	1/87	2/87	6/87	8/87						
BA[illegible]ES	12							3/86	8/86	1/87	2/87	6/87	8/87						
TA[illegible]	12							3/86	8/86	1/87	2/87	6/87	8/87						
LI[illegible] ROCK	19							5/86	10/86	3/87	4/87	8/87	10/87						
NE[illegible]RLEANS	19							3/86	8/86	1/87	2/87	6/87	8/87						
TOTAL STUDIES								11											

CHAUFFEURS REGION #4 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
CLEVELAND	13							1/86	6/86	11/86	12/86	4/87	6/87						
DAYTON	13							12/85	5/86	10/86	11/86	3/87	5/87						
BATTLE CREEK	14							1/86	6/86	11/86	12/86	4/87	6/87						
NORTH CHICAGO	17							3/86	8/86	1/87	2/87	6/87	8/87						
ST. LOUIS	21							12/85	5/86	10/86	11/86	3/87	5/87						
TOTAL STUDIES								5											

FIRE PROTECTION REGION #4 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/ME IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/ME IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/ME IMPL
CHILICOTHE	13	6/85	11/85	4/86	5/86	9/86	11/86												
CLEVELAND	13	6/85	11/85	4/86	5/86	9/86	11/86												
BATTLE CREEK	14	4/85	9/85	2/86	3/86	7/86	9/86												
MARION IN	14	4/85	9/85	2/86	3/86	7/86	9/86												
TOMAH	16	8/85	1/86	6/86	7/86	11/86	1/87												
HINES	17	4/85	9/85	2/86	3/86	7/86	9/86												
MARION IL	21	10/85	3/86	8/86	9/86	1/87	3/87												
TOTAL STUDIES		7																	

GROUNDS	REGION #4		A-76 Analysis																	
			Fiscal Year 1985						Fiscal Year 1986						Fiscal Year 1987					
FACILITY NAME	DST #	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/M IMP
CLEVELAND	12							3/86	8/86	1/87	2/87	6/87	8/87						
DAYTON	13							3/86	8/86	1/87	2/87	6/87	8/87						
BATTLE CREEK	14							7/86	12/86	5/87	6/87	10/87	12/87						
WOOD	16							1/86	6/86	11/86	12/86	4/87	6/87						
NORTH CHICAGO	17							6/86	11/86	4/87	5/87	9/87	11/87						
ST. LOUIS	21							3/86	8/86	1/87	2/87	6/87	8/87						
TOTAL STUDIES								6											

LAUNDRY REGION #4 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
CHILLICOTHE	13	8/85	1/86	6/86	7/86	11/86	1/87												
CLEVELAND	13	8/85	1/86	6/86	7/86	11/86	1/87												
DAYTON	13	8/85	1/86	6/86	7/86	11/86	1/87												
BATTLE CREEK	14	8/85	1/86	6/86	7/86	11/86	1/87												
MARION, IN	14	8/85	1/86	6/86	7/86	11/86	1/87												
MADISON	16							7/86	12/86	5/87	6/87	10/87	12/87						
TOMAH	16							7/86	12/86	5/87	6/87	10/87	12/87						
WOOD	16							7/86	12/86	5/87	6/87	10/87	12/87						
NORTH CHICAGO	17							10/85	3/86	8/86	9/86	1/87	3/87						
HINES	17							6/86	11/86	4/87	5/87	9/87	11/87						
ST. LOUIS	21	8/85	1/86	6/86	7/86	11/86	1/87												
TOTAL STUDIES		6						5											

PRINTING/REPRODUCTION REGION #4 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
CINCINNATI	13							12/85	5/86	10/86	11/86	3/87	5/87						
TOTAL STUDIES								1											

SWITCHBOARD REGION #4 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
CLEVELAND	13							11/85	4/86	9/86	10/86	2/87	4/87						
WOOD	16	9/85	2/86	7/86	8/86	12/86	2/87												
HINES	17	8/85	1/86	6/86	7/86	11/86	1/87												
TOTAL STUDIES		2						1											

TRANSCRIPTION REGION #4 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
CLEVELAND	13							9/86	2/87	7/87	8/87	12/87	2/88						
ALLEN PARK	14							9/86	2/87	7/87	8/87	12/87	2/88						
TOMAH	16							12/85	5/86	10/86	11/86	3/87	5/87						
WOOD	16							12/85	5/86	10/86	11/86	3/87	5/87						
HINES	17							12/85	5/86	10/86	11/86	3/87	5/87						
TOTAL STUDIES								5											

VCS FOOD REGION #4 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/ME IMPL
CINCINNATI	13	6/85	11/85	4/86	5/86	9/86	11/86												
DAYTON	13	6/85	11/85	4/86	5/86	9/86	11/86												
ALLEN PARK	14	5/85	10/85	3/86	4/86	8/86	10/86												
ANN ARBOR	14	5/85	10/85	3/86	4/86	8/86	10/86												
DANVILLE	15							5/86	10/86	3/87	4/87	8/87	10/87						
INDIANAPOLIS	15							5/86	10/86	3/87	4/87	8/87	10/87						
WOOD	16							4/86	9/86	2/87	3/87	7/87	9/87						
HINES	17							3/86	8/86	1/87	2/87	6/87	8/87						
COLUMBIA MO	21							11/85	4/86	9/86	10/86	2/87	4/87						
ST. LOUIS	21							11/85	4/86	9/86	10/86	2/87	4/87						
TOTAL STUDIES		4						6											

WAREHOUSE	REGION #4	A-76 Analysis																		
		Fiscal Year 1985						Fiscal Year 1986						Fiscal Year 1987						
FACILITY NAME	DST #	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
CINCINNATI	13	4/85	9/85	2/86	3/86	7/86	9/86												
CLEVELAND	13	4/85	9/85	2/86	3/86	7/86	9/86												
DAYTON	13	4/85	9/85	2/86	3/86	7/86	9/86												
ALLEN PARK	14	7/85	12/85	5/86	6/86	10/86	12/86												
BATTLE CREEK	14	7/85	12/85	5/86	6/86	10/86	12/86												
INDIANAPOLIS	15							8/86	1/87	6/87	7/87	11/87	1/88						
WOOD	16							8/86	1/87	6/87	7/87	11/87	1/88						
NORTH CHICAGO	17							1/86	6/86	11/86	12/86	4/87	6/87						
HINES	17							7/86	12/86	5/87	6/87	10/87	12/87						
ST. LOUIS	21							1/86	6/86	11/86	12/86	4/87	6/87						
TOTAL STUDIES		5																	
								5											

CHAUFFEURS — REGION #5 — A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C
LEAVENWORTH	22							12/85	5/86	10/86	11/86	3/87	5/87						
TOTAL STUDIES								1											

FIRE PROTECTION REGION #5 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/P IMP
MINNEAPOLIS	18							11/85	4/86	9/86	10/86	2/87	4/87						
LEAVENWORTH	22	9/85	2/86	7/86	8/86	12/86	2/87												
FT. MEADE	23	9/85	2/86	7/86	8/86	12/86	2/87												
KNOXVILLE	23	8/85	1/86	6/86	7/86	11/86	1/87												
FT. HARRISON	24	8/85	1/86	6/86	7/86	11/86	1/87												
FT. LYON	24	8/85	1/86	6/86	7/86	11/86	1/87												
SHERIDAN	24	8/85	1/86	6/86	7/86	11/86	1/87												
TOTAL STUDIES		6						1											

GROUNDS — REGION #5 — A-76 Analysis

FACILITY NAME	DST #	STUDY START	Fiscal Year 1985: MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986: STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987: STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
MINNEAPOLIS	18	8/85	1/86	6/86	7/86	11/86	1/87												
DALLAS	20	9/85	2/86	7/86	8/86	12/86	2/87												
HOUSTON	20	9/85	2/86	7/86	8/86	12/86	2/87												
WACO	20	9/85	2/86	7/86	8/86	12/86	2/87												
FT. LYON	24	9/85	2/86	7/86	8/86	12/86	2/87												
TOTAL STUDIES		5																	

LAUNDRY REGION #5 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
MINNEAPOLIS	18							5/86	10/86	3/87	4/87	8/87	10/87						
SIOUX FALLS	18							2/86	7/86	12/86	1/87	5/87	7/87						
ST. CLOUD	18							5/86	10/86	3/87	4/87	8/87	10/87						
DALLAS	20							12/85	5/86	10/86	11/86	3/87	5/87						
HOUSTON	20							1/86	6/86	11/86	12/86	4/87	6/87						
OKLAHOMA CITY	20							1/86	6/86	11/86	12/86	4/87	6/87						
SAN ANTONIO	20							1/86	6/86	11/86	12/86	4/87	6/87						
WACO	20							1/86	6/86	11/86	12/86	4/87	6/87						
LINCOLN	23	9/85	2/86	7/86	8/86	12/86	2/87												
OMAHA	23	9/85	2/86	7/86	8/86	12/86	2/87												
DENVER	24	6/86	11/86	4/87	5/87	9/87	11/87												
SALT LAKE CITY	24	6/86	11/86	4/87	5/87	9/87	11/87												
TOTAL STUDIES		4						8											

SWITCHBOARD REGION 05 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/ME IMPL
MINNEAPOLIS	18	7/85	12/85	5/86	6/86	10/86	12/86												
HOUSTON	20	7/85	12/85	5/86	6/86	10/86	12/86												
TOTAL STUDIES		2																	

TRANSCRIPTION REGION #5 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
MINNEAPOLIS	18							12/85	5/86	10/86	11/86	3/87	5/87						
HOUSTON	20							11/85	4/86	9/86	10/86	2/87	4/87						
SAN ANTONIO	20							11/85	4/86	9/86	10/86	2/87	4/87						
DENVER	24							11/85	4/86	9/86	10/86	2/87	4/87						
TOTAL STUDIES								4											

VCS FOOD — REGION #5 — A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
MINNEAPOLIS	18							2/86	7/86	12/86	1/87	5/87	7/87						
HOUSTON	20							12/85	5/86	10/86	11/86	3/87	5/87						
OKLAHOMA CITY	20							12/85	5/86	10/86	11/86	3/87	5/87						
SAN ANTONIO	20							12/85	5/86	10/86	11/86	3/87	5/87						
TEMPLE	20							12/85	5/86	10/86	11/86	3/87	5/87						
KANSAS CITY	22							11/85	4/86	9/86	10/86	2/87	4/87						
LEAVENWORTH	22							11/85	4/86	9/86	10/86	2/87	4/87						
TOPEKA	22							10/85	3/86	8/86	9/86	1/87	3/87						
DES MOINES	23	9/85	2/86	7/86	8/86	12/86	2/87												
IOWA CITY	23	9/85	2/86	7/86	8/86	12/86	2/87												
OMAHA	23	9/85	2/86	7/86	8/86	12/86	2/87												
DENVER	24	8/85	1/86	6/86	7/86	11/86	1/87												
TOTAL STUDIES		4						8											

WAREHOUSE	REGION #5	A-76 Analysis																			
		Fiscal Year 1985						Fiscal Year 1986						Fiscal Year 1987							
FACILITY NAME	DST #	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE		
MINNEAPOLIS	18							6/86	11/86	4/87	5/87	9/87	11/87								
HOUSTON	20							3/86	8/86	1/87	2/87	6/87	8/87								
OKLAHOMA CITY	20							3/86	8/86	1/87	2/87	6/87	8/87								
SAN ANTONIO	20							3/86	8/86	1/87	2/87	6/87	8/87								
WACO	20							3/86	8/86	1/87	2/87	6/87	8/87								
TOTAL STUDIES								5													

WAREHOUSE REGION #6 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
LONG BEACH	26	9/85	2/86	7/86	8/86	12/86	2/87												
SAN DIEGO	26	9/85	2/86	7/86	8/86	12/86	2/87												
WEST LOS ANGELES	26	9/85	2/86	7/86	8/86	12/86	2/87												
PALO ALTO	27	9/85	2/86	7/86	8/86	12/86	2/87												
SAN FRANCISCO	27	9/85	2/86	7/86	8/86	12/86	2/87												
PORTLAND	28	8/85	1/86	6/86	7/86	11/86	1/87												
SEATTLE	28	8/85	1/86	6/86	7/86	11/86	1/87												
TOTAL STUDIES		7																	

VCS FOOD REGION #6 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
PHOENIX	25	7/85	12/85	5/86	6/86	10/86	12/86												
TUCSON	25	7/85	12/85	5/86	6/86	10/86	12/86												
LOMA LINDA	26	6/85	11/85	4/86	5/86	9/86	11/86												
LONG BEACH	26	6/85	11/85	4/86	5/86	9/86	11/86												
SAN DIEGO	26	6/85	11/85	4/86	5/86	9/86	11/86												
WEST LOS ANGELES	26	6/85	11/85	4/86	5/86	9/86	11/86												
FRESNO	27	5/85	10/85	3/86	4/86	8/86	10/86												
PALO ALTO	27	5/85	10/85	3/86	4/86	8/86	10/86												
AMERICAN LAKE	28	4/85	9/85	2/86	3/86	7/86	9/86												
PORTLAND	28	4/85	9/85	2/86	3/86	7/86	9/86												
SEATTLE	28	4/85	9/85	2/86	3/86	7/86	9/86												
TOTAL STUDIES		11																	

TRANSCRIPTION REGION #6 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE
LONG BEACH	26													10/86	3/87	8/87	9/87	1/88	3/88
W. LOS ANGELES	26													10/86	3/87	8/87	9/87	1/88	3/88
PALO ALTO	27	8/85	1/86	6/86	7/86	11/86	1/87												
PORTLAND	28	7/85	12/85	5/86	6/86	10/86	12/86												
SEATTLE	28	7/85	12/85	5/86	6/86	10/86	12/86												
TOTAL STUDIES		3												2					

SWITCHBOARD REGION #6 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985						Fiscal Year 1986						Fiscal Year 198		
		STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D
LONG BEACH	26	7/85	12/85	5/86	6/86	10/86	12/86										
W. LOS ANGELES	26	6/85	11/85	4/86	5/86	9/86	11/86										
PALO ALTO	27	6/85	11/85	4/86	5/86	9/86	11/86										
SAN FRANCISCO	27	6/85	11/85	4/86	5/86	9/86	11/86										
TOTAL STUDIES		4															

MAIL-MESSENGER REGION #6 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 19 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D
W. LOS ANGELES	26							3/86	8/86	1/87	2/87	6/97	8/87				
TOTAL STUDIES								1									

REGION #6 A-76 Analysis

LAUNDRY FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC
PHOENIX	25	9/85	2/86	7/86	8/86	12/86	2/87											
SAN DIEGO	26	8/85	1/86	6/86	7/86	11/86	1/87											
WEST LOS ANGELES	26	8/85	1/86	6/86	7/86	11/86	1/87											
PALO ALTO	27	7/85	12/85	5/86	6/86	10/86	12/86											
AMERICAN LAKE	28	7/85	12/85	5/86	6/86	10/86	12/86											
PORTLAND	28	6/85	11/85	4/86	5/86	9/86	11/86											
TOTAL STUDIES		6																

INTERIOR DESIGN — REGION #6 — A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 START DATE	FTEE	COST ($000)	Fiscal Year 1986 START DATE	FTEE	COST ($000)	Fiscal Year 1987 START DATE	FTEE	COST ($000)
WEST LOS ANGELES	26				APR. 86	10	174			
TOTALS					1	10	174			
MAXIMUM						10	174			
MINIMUM						10	174			
AVERAGE						10	174			

GROUNDS REGION #6 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE
LONG BEACH	26							1/86	6/86	11/86	12/86	4/87	6/87					
WEST LOS ANGELES	26							2/86	7/86	12/86	1/87	5/87	7/87					
TOTAL STUDIES								2										

FIRE PROTECTION REGION #6 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985					Fiscal Year 1986					Fiscal Year 1987				
		STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC/MEO CLOSE/IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC/MEO CLOSE/IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLO
LIVERMORE	27	8/85	1/86	6/86	7/86	11/86/ 1/87										
AMERICAN LAKE	28	7/85	12/85	5/86	6/86	10/86/12/86										
WHITE CITY	28	7/85	12/85	5/86	6/86	10/86/12/86										
TOTAL STUDIES		3														

ACTIVITIES TO BE STUDIED FOR POSSIBLE CONTRACTING OUT UNDER THE PROVISIONS OF OMB CIRCULAR A-76

The question of what type activities ought to be studied for possible contracting out has been under study in the Department and the Agency for a number of years. In 1984 the Chief Medical Director made formal decisions to study the following non-medical activities, in approximately 100 locations: Laundry, canteen food, warehouse, fire protection, transcription, grounds maintenance, chauffeur, switchboard, mail-messenger, furniture repair, interior design, design-drafting and data entry.

In general these studies would examine functions performed by approximately 5,000 FTEE, and would be conducted over a three-year period. The Agency believes decisions to subsequently contract out these activities would not impair the quality of care to our patients. The ground rules for such studies will be guided by requirments of Title 38, USC, Section 5010(c).

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, DC., October 25, 1984.

Hon. G. V. MONTGOMERY,
Chairman, Committee on Veterans' Affairs, House of Representatives,

DEAR MR. CHAIRMAN: For appropriations to the Veterans Administration's (VA's) medical care and related accounts, 38 U.S.C. 5010(a)(4) requires the Comptroller General to report to the House and Senate Appropriations and Veterans' Affairs Committees whether the Director of the Office of Management and Budget (OMB) provided to VA the funds and personnel ceilings specified.

The Department of Housing and Urban Development-Independent Agencies Appropriation Act, 1985 (Public Law 98-371), appropriated the funds shown below to VA's medical care and related accounts to support the indicated personnel ceilings.

Account	Appropriations	Personnel ceiling [1]
Medical care	$8,792,165,000	193,941
Medical and prosthetic research	192,695,000	4,625
Medical administration and miscellaneous operating expenses	70,000,000	860

[1] Full-time equivalent employees.

In accordance with section 5010(a)(4)(B), OMB has provided to VA the funds appropriated by the act and the personnel ceilings shown above.

Sincerely yours,

CHARLES A. BOWSHER,
Comptroller General of the United States.

[Excerpt from the HUD and Independent Agencies Report of June 26, 1984]

This amount of funding is specifically intended to support 193,941 full-time equivalent employees (FTEEs) with the understanding that, in accordance with established Congressional practice, any additional pay costs necessary to support that FTEE level will be borne by the VA, using funds made available by this measure, funds made available through the enactment of supplemental appropriations, or through absorption of the costs, or some combination thereof. This FTEE level does not include common services FTEEs.

[Western Union telegram]

THE AMERICAN LEGION,
Washington, DC, February 6, 1985.

Hon. BOB EDGAR,
Chairman, House Veterans Affairs Subcommittee on Hospitals and Health Care, Cannon House Office Building, Capitol Hill, DC.

I have just completed a preliminary review of the administration's proposed budget for VA in fiscal year 1986, and I find it unsatisfactory in several areas.

The American Legion cannot accept the proposed 400 percent increase in the VA home loan user fee. Also, we are convinced that any reductions in VA health care personnel, imposition a meaningless means test on veterans who are sick and poor, and mostly old, and the consolidation of most VA services out of VA regional officers are unwise in the face of an American population that is living longer and thus requiring more attention to health care. If the current proposed reductions in veterans programs are allowed to be accepted it would adversely impact not only America's veterans but all Americans.

As an agency which has seen its portion of the total federal budget decreased by almost 50 percent over the past 10 years, VA has demonstrated its cost effectiveness, neither the agency nor the veterans community can afford the proposed reductions.

The American Legion will be prepared to present its views on these important matters when it is given the opportunity to do so. WE earnestly ask the Congress to insure that veterans programs are fully and adequately funded for FY 1986 and outyears.

CLARENCE M. BACON,
National Commander.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

HON. JAMES J. FLORIO TO DR. JOHN DITZLER, VETERANS' ADMINISTRATION

Question 1. Has the recent Medical District Initiated Program Plan noted that placement of a satellite outpatient facility in New Jersey is a very high priority of VA Medical District IV? Is it the highest priority in District IV as far as out-patient clinics are concerned?

Answer. The 1984 MEDIPP submission shows the proposal for a satellite outpatient clinic (SOC) in New Jersey as a modernate priority with a rank of 94 out of a total of 175 proposals (approximately, 46th percentile).

Within Medical District IV, the New Jersey proposal is the higher priority of the two SOCs proposed.

Question 2. What is the minimum number of annual visits which the VA mandates must exist before consideration of such a satellite facility is considered? How many have you projected for the New Jersey site? Is there another site in the entire Medical District IV which has a higher minimum number of visits?

Answer. The minimum number of annual visits required for a satellite outpatient clinic (SOC) proposal is 15,000. The New Jersey SOC proposal contained a maximum projection of approximately 52,000 visits of which the Medical District proposed a startup level of 25,000 visits. (This is not unusual since the maximum number projected counts those visits to existing VA facilities already coming from the proposed PSA. The Medical District would have to base future changes in visit levels on the actual experience of the new SOC.) The maximum projected visits for the New Jersey SOC of 52,000 exceed the 47,000 maximum projected visits for the newly proposed Pennsylvania SOC by approximately 5,000 visits.

Question 3. When does the Veterans Administration plan to recommend such a site in New Jersey?

Answer. The 1984 MEDIPP submission showed a need for the proposed New Jersey satellite outpatient clinic (SOC) in 1990; however, the Medical District has recently indicated that it is going to change the proposal to show a need in 1987. The actual timeframe in which the VA will request funding for the proposed SOC in New Jersey will depend first on whether the proposal is approved (it is still under review in VACO). If approved, the proposal will be compared with similar proposals from other medical districts with respect to national priorities and needs.

Question 4. It is my understanding that Dr. Earl Brown has informed my staff that the VA is developing yet another priority ranking method to supercede the MEDIPP system. I would like to obtain a listing of proposed outpatient facilities nationally and in the order of priority which your agency intends to pursue their establishment. If your new system is not yet ready is it possible to obtain that ranking order as derived from the existing MEDIPP plan? It was only several years ago that Congress was told that MEDIPPs would be able to produce this sort of product.

Answer. The "priority ranking method" alluded to by Dr. Earl Brown is part of the VA Central Office MEDIPP review process whereby competing satellite outpatient clinic (SOC) proposals from many VA medical districts will be ranked on a national basis. A ranking of all approved SOC proposals will be available at the end of the 1984 MEDIPP review process. The existing SOC methodology is designed to

assist VA medical districts in analyzing their needs for such facilities. The methodology is district-specific and allows planners to evaluate the comparative needs of various sites within a medical district. Because MEDIPP is a district-based planning process, there is no provision to have the VA medical districts assess the relative merits of SOC proposals versus those of other medical districts. This type of assessment is the perogative of the VA Central Office review process. All SOC proposals which meet the basic criteria for submission and which are approved will be collated and ranked. Until this part of the review is undertaken, it is not possible to obtain a ranking order from the MEDIPP submission except for multiple proposals from one medical district which would be ranked.

Question 5.—Given the pressing need existent in New Jersey, I am interested in learning exactly what methods are utilized by the VA to determine the best possible site for such a facility. Demographics aside, is there an inventory made of existing sites which may be leased long term? Is there a determined effort to ascertain which areas of a chosen area would be most receptive to such a facility, both economically and medically? Preliminary statistics given to me from sources in New Jersey place the cost of such a clinic at significantly less than VA estimates.

Answer. After we have broadly defined a general area of consideration for establishing an outpatient clinic using demographic profiles, an on-site market survey is conducted. The purpose of this survey is to collect general information on public transit routes, zoning restrictions, community development objectives, tax assessment rates, land values, local construction costs, real estate sale values, local rental costs and local medical facilities. This information is then used to establish a delineated area within which to site the clinic. It is our intent during this process to define an area affording reasonable access for patients, proximity to other health care providers, reasonable acquisition costs and opportunity for a competitive procurement.

While conducting the market survey, interviews are held with community planning officials, real estate brokers, real estate appraisers, tax assessors and builders and zoning officials. The data collected during the survey is then used to complete a life cycle cost analysis which compares the cost effectiveness of acquisition methods (lease, purchase or build). If leasing is determined to be the preferred method of acquisition, the procurement process will be through competitive bid. Advertisements are then placed in community newspapers, and all interested offerers having property within the delineated area are invited to bid. Persons expressing a verbal or written interest in providing property correspondence are forwarded a copy of the Solicitation for Offers.

One of the primary purposes of VA's market survey is to define a specific delineated area for a clinic site, within a much broader area of consideration. The collection of economic data is an integral part of this process, and economic considerations are factors in defining the boundaries of the delineated area. During the market survey there are consultations with local officials in charge of community planning. Community planning objectives and zoning restrictions are key decision factors.

With respect to the community's receptivity to the VA's medical presence, I would submit that VA clinics serve the veteran population. As such, the concern of VA is generally limited to the medical reception within that segment of the community. In the early stages of project development the medical needs of veterans in the patient service area are assessed. Outpatient clinics are designed and staffed to meet user demands. Veterans groups and service organizations play an active role by advocating and articulating the need for special clinic services. At this time, the VA has not completed a market survey or cost analysis for a New Jersey clinic. Therefore, specific cost estimates are unavailable.

Question 6. I would like a hypothetical line item cost estimate of an out-patient clinic. This would include salaries, equipment cost, pharmacy inventory, cost of renovation (if leasing) and security, as well as any other cost you may think applicable to such a hypothetical facility. If local costs and estimates present a problem I suggest that you utilize southern Ocean County or northern Atlantic County, New Jersey as your proposed site. Either location would suit this hypothetical scenario for our needs.

Answer. Cost estimates for a hypothetical clinic in southern Ocean County or northern Atlantic County, New Jersey, are presented below. Rental costs are predicated on data provided by the General Services Administration (GSA) to project the Fiscal Year 1986 Standard Level Users Charge for GSA Region 1, Limited Federal Space Areas. The costs of salaries, supplies and equipment are predicated on VA's historic data. The hypothetical workload is 25,200 annual outpatient visits with a space requirement of 22,000 net rentable square feet.

Recurring costs:	
Salaries (56 FTEE)	$1,540,000
Supplies	706,000
Rent (office, clinic and parking space)[1]	421,500
Total	2,667,500
Nonrecurring costs:	
Equipment	1,800,000
Other (furnishings, start-up, move-in)	200,000
Total	2,000,000

[1] Cost of special purpose renovations is amortised in rent. Services and utilities are included.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC., February 7, 1985.

Hon. BOB EDGAR,
Chairman, Subcommittee on Hospitals & Health Care, Veterans' Affairs Committee, U.S. House of Representatives, Washington, DC.

DEAR BOB: Congratulations on your recent reelection to the post of Chairman of the Health & Hospitals Subcommittee. As a subcommittee Member I, particularly, have appreciated your leadership and thoroughness in the past.

I would like to include some material in the record of today's proceedings of the Health & Hospitals Subcommittee. Unfortunately, my schedule does not permit my attendance but I will respond to the statement which you made at this morning's photo session. I have several questions which I would like Dr. Ditzler to answer and would be happy if they were passed along as well.

The materials which I would like placed into the record are enclosed. They are two letters, copies of which you have already received. The letters are to Messrs. Walters and Stockman, respectively, and concern plans for the placement of a satellite outpatient facility in New Jersey. I would be grateful if they could be placed into the official record at my request.

Please find attached a list of questions to which I would like Dr. Ditzler's response. I intend to share his response with my fellow colleagues from New Jersey who are also interested in this matter.

Thank you for your cooperation in this effort. I congratulate you again on your reelection and I look forward to working with you in the future.

With best wishes,

Sincerely,

JAMES J. FLORIO, *Member of Congress.*

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, January 24, 1985.

Hon. DAVID A. STOCKMAN,
Director, Office of Management and Budget, Executive Office Building, Washington, DC.

DEAR MR. STOCKMAN: As you may know, the 1984 Veterans Administration Medical District Initiated Program Planning (MEDIPP) study includes a recommendation to establish an ambulatory care facility in New Jersey through the fiscal 1987 budget. Of the entire VA Medical District IV—which encompasses New Jersey, Delaware, and parts of Maryland and Pennsylvania—the New Jersey site is recognized as the highest priority. The facility, better known as a "satellite outpatient clinic," will treat minor surgery, fill pharmaceutical needs and provide local diagnostic and rehabilitative services.

The Veterans Administration has relied upon these locally placed facilities as a means of lessening the workload at the primary VA Medical Centers. This farsighted policy is based on the idea that adapting to the geographical changes in veterans population is less expensive in the long term. Additionally, the medical care for comparatively minor problems can be offered in a local, more convenient manner for the veteran.

Dispite this theory, the nearly one million veterans of New Jersey have suffered for many years. The only outpatient facility in the state is located in Newark and has been victimized by staffing shortages and equipment breakdowns. VA statistics

indicate that there are regions of New Jersey which are capable of providing over 52,000 visits per year by veterans to an outpatient clinic. The minimum threshold cited by the VA for the placement of a clinic is only 15,000 visits annually, less than one-third of the projected annual total for the New Jersey site.

While we are aware of the necessity for fiscal restraint this year, we are convinced that the case for a VA satellite outpatient clinic in New Jersey is so compelling that inclusion of such a clinic in the 1986 budget is warranted. From a demographic perspective, the elderly population in New Jersey is growing at a tremendous rate. This added crunch will place a further strain on a veterans health care network that is already chronically overtaxed.

As federal policymakers, we are acutely concerned about meeting the needs of the millions of World War II and Korean War veterans who will become eligible for free health care benefits over the next 15 years. The recent VA study, "Caring for the Older Veteran," predicted that by 1990, 7.2 million veterans will be over 65, doubling 1980's total. We have the opportunity before us this year to establish a facility to serve the unmet demand which existed before 1980, while simultaneously preparing for the continuing influx of older veterans to our region. It is for these men and women that we repeat the recommendations of that report and the recommendations of health professionals in the field. The establishment of an outpatient clinic in New Jersey is a priority and it must be a priority this year.

We are ready and willing to work with you through the legislative process this year to facilitate this action. As the elected representatives of the nearly one million New Jersey veterans, it is our honor and privilege to work toward this goal.

Sincerely,

Chris Smith, Member, Veterans' Affairs Committee. Frank R. Lautenberg, Jim Saxton, Matt Rinaldo, Marge Roukema, Frank J. Guarini, Bill Hughes, Robert G. Torricelli, James J. Florio, Bill Bradley, Dean A. Gallo, Jim Courter, James J. Howard, Robert A. Roe, Bernard J. Dwyer, Peter W. Rodino, Jr.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, January 24, 1985.

Hon. HARRY N. WALTERS,
Administrator, Veterans Administration,
Washington, DC.

DEAR MR. WALTERS: As you may know the 1984 Veterans Administration Medical District Initiated Program Planning (MEDIPP) study includes a recommendation to establish an ambulatory care facility in New Jersey through the FY 1987 budget. Of the entire VA Medical District IV—which encompasses New Jersey, Delaware and parts of Maryland and Pennsylvania—the New Jersey site is recognized as the highest priority. The facility, better known as a "satellite outpatient clinic", will treat minor surgery, fill pharmaceutical needs and provide local diagnostic and rehabilitative services.

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The nearly one million veterans of New Jersey have suffered despite this theory for many years. The only outpatient facility in the state is located in Newark and has been victimized by staffing shortages and equipment breakdowns. VA statistics indicate that there are parts of New Jersey which are capable of providing over 52,000 visits per year by veterans to such a facility. The minimum threshold cited by the VA for the placement of a clinic is only 15,000 visits annually, less than one-third of the projected annual total for the New Jersey site.

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Sincerely,

Chris Smith, Member, Committee on Veterans' Affairs. Frank R. Lautenberg, Matt Rinaldo, Jim Saxton, Marge Roukema, Frank J. Guarini, Bill Hughes, Robert G. Torricelli, James J. Florio, Bill Bradley, Jim Courter, Dean A. Gallo, James J. Howard, Robert A. Roe, Bernard J. Dwyer, Peter W. Rodino, Jr.

MEDICAL CARE—EMPLOYMENT ANALYSIS

	1984 actual	1985		1986 estimate	Increase (+) Decrease (−)
		Budget	Estimate		
FTEE by type:					
Nurses	32,583	32,142	32,925	32,956	+31
Dentists	1,046	1,062	1,052	1,058	+6
Physicians	12,122	12,513	12,249	12,261	+12
Psychologists	1,441	1,465	1,450	1,458	+8
Wage board	34,350	35,356	34,710	34,744	+34
Purchase and hire	161	287	161	159	−2
Other personnel	108,760	111,086	109,901	110,009	+108
Total, net	190,463	193,911	192,448	192,645	+197
Less, common services	−598	−590	−599	−597	+2
Total, jurisdictional	189,865	193,321	191,849	192,048	+199
FTEE by activity:					
Medical bed sections	59,551	62,005	59,255	59,118	−137
Surgical bed sections	35,226	35,467	35,010	34,560	−450
Psychiatric bed sections	32,863	33,614	32,789	32,555	−234
Intermediate bed sections	14,104	14,360	14,275	14,393	+118
VA hospitals	141,744	145,446	141,329	140,626	−703
VA nursing homes	11,241	11,577	12,369	13,129	+760
VA domiciliaries	2,360	2,566	2,296	2,283	−13
Outpatient programs	30,476	32,509	31,592	31,791	+199
Miscellaneous benefits and services	3,759	1,311	3,979	3,942	−37
Non-VA programs support	883	502	883	874	−9
Total, net	190,463	193,911	192,448	192,645	+197
Less, common services	−598	−590	−599	−597	+2
Total, jurisdicational	189,865	193,321	191,849	192,048	+199
Included above:					
(Education and training support)	(9,087)	(8,847)	(9,182)	(9,137)	(−45)
(Chaplain service)	(675)	(675)	(675)	(668)	(−7)

BUDGET AUTHORITY

[In thousands of dollars]

Appropriation/fund account	1984	1985	1986	Increase (+) Decrease (−)
Federal funds:				
Benefit programs:				
Compensation	$9,952,512	$10,222,481	$10,186,000	−$36,481
Pensions	3,916,000	3,811,419	3,838,000	+26,581
Burial benefits and miscellanecus assistance	128,388	134,000	136,800	+2,800
Readjustment benefits	1,443,200	1,182,000	1,026,000	−156,000
Veterans insurance and indemnities	7,400	11,000	9,750	−1,250
Reinstated entitlement program for survivors	51,000			
Emergency veterans job training	130,000			
Loan guaranty revolving fund	260,000	306,600	404,600	+98,000
Total benefit programs	15,888,500	15,667,500	15,601,150	−66,350
Medical programs:				
Medical care	8,244,414	8,854,428	9,090,000	+235,572
Medical and prosthetic research	217,680	192,372	187,080	−5,292
Medical administration and miscellaneous operating expenses	66,552	67,891	55,879	−12,012
Grants for construction of state extended care facilities	18,000	34,500	22,000	−12,500
Grants to the Republic of the Philippines	500	500	500	
Total medical programs	8,547,146	9,149,691	9,355,459	+205,768
Construction programs:				
Construction, major projects	345,692	568,194	417,200	−150,994
Construction, minor projects	185,378	199,823	194,400	−5,423
Total construction programs	531,070	768,017	611,600	−156,417
General operating expenses and miscellaneous:				
General operating expenses	715,676	754,052	749,412	−4,640
Grants for the construction of state veterans cemeteries	3,000	5,000	3,000	−2,000
Total GOE & miscellaneous	718,676	759,052	752,412	−6,640
Total appropriations, adjusted	25,685,392	26,344,260	26,320,621	−23,639
Proposed legislation:				
Compensation			342,800	+342,800
Loan guaranty revolving fund			−404,600	−404,600
Total proposed legislation			−61,800	−61,800
Proprietary receipts from the public	−59,070		−65,000	−65,000
Total federal funds	25,626,392	26,344,260	26,193,821	−150,439
Trust Funds:				
Post-Vietnam era veterans education account	224,776	218,000	171,000	−47,000
General post fund	13,447	14,000	15,000	+1,000
National service life insurance	1,248,781	1,248,900	1,297,200	+48,300
U.S. Government life insurance	23,279	20,900	18,800	−2,100
Total trust funds (gross)	1,510,283	1,501,800	1,502,000	+200
Proprietary receipts from the public	−617,028	−560,100	−515,250	+44,850
Total trust funds (net)	893,255	941,700	986,750	+45,050
Intragovernmental transactions	−51,008	−52,775	−70,939	−18,164
Total Veterans Administration	26,468,569	27,233,185	27,109,632	−123,533

OPENING STATEMENT BY CONGRESSMAN MIKE BILIRAKIS, FEBRUARY 7, 1985, SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

Mr. Chairman. the Administration's budget contains a number of proposals which would significantly change the way in which the costs of medical care for veterans are distributed.

Perhaps the proposal which has provoked the loudest cries of opposition—and I have certainly heard from my own constituents on this matter—is the means test for non-service-connected veterans. But those of us who represent states like Florida, whose veteran population has far outstripped the resources allocated to us for medical care, already know what it is like to have constituents turned away or forced to wait months for an appointment on the basis of priorities which we have established here in Washington. And I do believe that our service-connected veterans and POWs deserve some priority.

However, the basic problem is one of limited resources in the face of rising demand for care and I believe a second Administration proposal deserves our close attention in this regard. That proposal is third party reimbursement.

I know that many veterans' organizations have opposed such a move in the past but I would urge them to reevaluate their position. Private insurance companies, not veterans, are the primary beneficiaries of our present policy against third party reimbursement. I believe it is time we looked closely at this option for increasing V.A. resources at a time when we are being pressured to restrict eligibility for care. I suggest that third party reimbursement offers a much more more positive course of action. Thank you, Mr. Chairman.

INCOME OF THE AGING VETERAN

(By age group)

There are several sources of information on family income of veterans that is available to the Veterans Administration; a 1979 Survey of Veterans done by the Bureau of the Census for the Veterans Administration, a Survey of Aging Veterans done by Louis Harris and Associates, Inc. in 1983.

The 1983 Louis Harris Report was based upon a sample of the veteran population aged 55 or over on September 30, 1983. Use or non-use of VA medical facilities was not a factor in the sample.

TOTAL ANNUAL INCOME

Question. What was the total income that you/you and your wife/husband received last year from all sources?

	Total	Age				
		55 to 59	60 to 64	65 to 69	70 to 74	75 and over
Base income	$3,013	$920	$1,057	$621	$240	$175
Percentage:						
Less than $5,000	5	3	4	5	6	12
$5,000 to $9,999	13	8	10	17	24	31
$10,000 to $14,999	14	8	15	20	22	18
$15,000 to $19,999	11	8	11	15	12	11
$20,000 to $24,999	11	12	12	10	9	6
$25,000 to $29,999	8	9	9	7	4	2
$30,000 to $34,999	8	12	8	5	3	2
$35,000 to $39,999	5	8	5	2	1	2
$40,000 to $44,999	4	5	4	2	1	2
$45,000 to $49,999	3	4	3	1	1	.....
$50,000 to $54,999	2	3	2	1	1	(1)
$55,000 to $59,999	1	2	1	1	(1)	.....
$60,000 or more	5	7	6	3	2	2
Median income (in thousands)	$20.9	$28.4	$22.6	$16.1	$13.1	10.9
Mean income (in thousands)	23.8	29.2	25.2	19.1	16.2	14.4

[1] Less than 0.5 percent.

The 1979 Survey of Veterans did not split its income analysis by age. Below is a family income distribution for patients hospitalized in 1978 by type of hospital.

PERCENT DISTRIBUTION OF INCOME OF VETERANS HOSPITALIZED IN 1978 BY TYPE OF HOSPITAL

	VA medical centers	Non-VA hospitals
All incomes (in thousands)	$513	$3,405
Percentage	100.0	100.0
Less than $5,000	22.6	6.2
$5,000 to $9,999	35.3	13.6
$10,000 to $14,999	12.7	17.4
$15,000 to $19,999	13.0	15.5
$20,000 to $24,999	[1] 6.8	15.2
$25,000 and over	[1] 4.2	26.2

[1] Estimate has large sampling variability due to the small number of sample persons in the cell.

Note.—69,000 veterans used both VA and non-VA hospitals, therefore they are included in both VA medical centers and in non-VA hospitals. Family income is used in this table.

Another report from background interview tapes follows. This chart was not published in the 1979 SOV but was furnished to the Office of Management and Budget at their request. (It should be noted that 9,929 non-institutional male veterans were interviewed for this Survey. The figures in the following chart are weighted figures and not the summary of individual interviews.)

1979 NATIONAL SURVEY OF VETERANS INCOME BY TYPE OF HOSPITALIZATION AND BENEFICIARY CATEGORY

Income	VA Hospital			Other Hospital			Total
	SC disability	Pension	Other	SC disability	Pension	Other	
Under $1,000	0	0	2,621	0	2,763	8,633	14,017
1,000 to 1,999	8,162	0	5,285	2,399	0	5,855	21,701
2,000 to 2,999	9,695	0	14,006	6,195	0	22,136	52,032
3,000 to 3,999	9,759	21,523	14,266	4,598	19,424	20,096	89,666
4,000 to 4,999	2,349	5,871	19,896	14,937	19,650	84,826	147,530
5,000 to 5,999	13,231	22,107	21,328	5,348	21,306	52,175	135,495
6,000 to 7,499	12,780	16,119	17,890	23,920	19,549	102,624	192,883
7,500 to 9,999	9,267	16,489	39,997	14,092	7,458	187,785	275,087
10,000 to 11,999	10,370	0	11,634	26,679	5,079	206,849	260,611
12,000 to 14,999	23,846	2,113	13,926	40,394	5,410	303,789	389,479
15,000 to 19,999	37,856	8,754	20,180	32,749	0	486,109	585,648
20,000 to 24,999	14,155	0	20,582	43,006	0	471,127	548,871
25,000 to 49,999	14,815	0	3,277	62,269	0	709,816	790,177
50,000 and over	0	0	3,467	5,819	0	111,961	121,247
Don't know	5,761	7,658	5,020	5,391	0	10,837	34,667
Refused	2,920	0	6,441	10,255	0	159,989	179,604
No answer	0	0	0	5,280	0	5,692	10,972
Total	174,966	100,635	219,815	303,332	100,639	2,950,299	3,849,686

Note.—This includes male veterans who reported they had stayed overnight or longer in a hospital in 1978.

DATA/KEYPUNCH — REGION #6 — A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985						Fiscal Year 1986						Fiscal Year 1987				
		STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOL CLC
W. LOS ANGELES	26							5/86	10/86	3/87	4/87	8/87	10/87					
TOTAL STUDIES								1										

CHAUFFEURS REGION 06 A-76 Analysis

FACILITY NAME	DST #	Fiscal Year 1985 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1986 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C/MEO IMPLE	Fiscal Year 1987 STUDY START	MEO COMPL	PWS COMPL	SOLIC ISS'D	SOLIC CLOSE	C
W. LOS ANGELES	26							11/85	4/86	9/86	10/86	2/87	4/87						
TOTAL STUDIES								1											